STATE OF MONTANA

EMPLOYEE BENEFITS SUMMARY PLAN DOCUMENT

Effective January 1, 2003

CONTENTS

CHAPTER 1
ELIGIBILITY, ENROLLMENT AND DATES OF COVERAGE

A. WHO IS ELIGIBLE

A.1 ELIGIBLE EMPLOYEE

If you are an employee of a participating department or agency of the State of Montana and are in one of the following classifications, you are eligible to enroll in the State Employee Benefit Plan:

1. Permanent full-time employee scheduled to work more than six months in any 12-month period.
2. Permanent part-time or job-share employee regularly scheduled to work 40 hours or more per pay period, and more than six months in any 12-month period.
3. Seasonal employee:
   a. regularly scheduled to work 40 hours or more per pay period for six months or more a year; or
   b. who works 40 hours or more per pay period for a continuous period of more than six months a year, although not regularly scheduled to do so.
4. Elected official.
5. Officer or permanent employee of the legislative branch.
6. Judge or permanent employee of the judicial branch.
7. Temporary employee:
   a. regularly scheduled to work 40 hours or more per pay period for more than six months within a year; or
   b. who works for 40 hours or more per pay period for a continuous period of more than six months, although not regularly scheduled to do so; or
   c. who is covered under a labor union contract that provides for eligibility.
8. Member of the Legislature.

A.2 ELIGIBLE DEPENDENT

Eligible dependents include:

1. The eligible employee's lawful spouse or declared common law spouse. (Affidavit of common law marriage forms may be obtained from the Employee Benefits Bureau (EBB).)
2. The eligible employee's dependent children who are under age 25, unmarried, not employed with an organization for which the dependent is entitled to group insurance, and not in full-time active military service. Dependent children are:
   a. natural or legally adopted children of the eligible employee or the employee's lawful or declared common law spouse; or
   b. any other child:
      1) with whom the eligible employee maintains a parent-child relationship, and
      2) who qualifies as a dependent of the eligible employee under Internal Revenue Codes, as amended.

      A parent-child relationship is defined as:
      a) court ordered custody of the child by the employee or the employee's lawful or declared common law spouse; or
      b) legal guardianship of the child by the employee or the employee's lawful or declared common law spouse.

      If a question arises as to the eligibility of a dependent as described in this provision, proof of the parent-child relationship and dependent status for Internal Revenue Code purposes must be submitted upon request to the EBB for review and approval.

A child cannot be covered by the State Employee Benefit Plan as an eligible dependent of more than one eligible employee, under the same coverage (medical or dental — see B.4).

A.3 Eligible Disabled Dependent

An employee's unmarried dependent children who are incapable of self-sustaining employment by reason of mental retardation or a physical disability will continue to be eligible for medical, dental, and life benefits after age 25 provided all of the following conditions are met.

1. The eligible employee continues dependent coverage.
2. The incapacity commenced prior to the date the dependent child's coverage would otherwise terminate.
3. The child is dependent upon the eligible employee for support and maintenance within the current meaning of Internal Revenue Codes.

Notification and proof of such incapacity must be submitted to the State Plan's claims administration company within 31 days of the date the dependent child's coverage would otherwise terminate. Forms are available from the EBB. Proof that the child is fully incapacitated may be required periodically.

A.4 Important Notice – Responsibility to Remove Ineligible Dependents

It is the responsibility of the subscriber (employee, retiree, COBRA enrollee, or surviving spouse) to remove any dependents, who cease to be eligible as defined in Section A.2 or A.3, from coverage within 31 days of the date eligibility is lost. The subscribing employee, retiree, COBRA enrollee, or surviving spouse will be held responsible for repayment of any claims dollars paid out for an ineligible dependent which exceed premiums collected for the ineligible dependent. Also, premiums paid pre-tax cannot be refunded.

B. HOW TO ENROLL

B.1 Enrollment of Newly Eligible Employees and Their Dependents During the First 31-Day Initial Enrollment Period

1. WHETHER TO ENROLL IN CORE BENEFITS FOR YOURSELF

A new employee who is eligible for benefits and an existing employee who becomes eligible for benefits must, within 31 days from the first day of eligibility, see their agency payroll personnel and either:

a. enroll and receive state contribution toward the cost of benefits; or
b. sign a waiver of benefits and forego state contribution.

Core Benefits Are:

a. employee medical insurance – you choose one of the available medical plans for the remainder of the benefit year and automatically receive the state-sponsored Employee Assistance Program and Prescription Drug Plan (subject to the provisions of C.5);
b. employee dental insurance; and
c. basic (Plan A) employee life insurance.

See a current rate sheet for premium costs and state contribution, available from agency payroll personnel.

Enrollment Options for Legislators

Legislators may:

a. enroll and receive state contribution toward the cost of benefits;
b. sign an Option 2 Authorization waiving State Plan coverage and applying state contribution toward any out-of-pocket premium costs for other health insurance; or
c. sign a waiver of benefits and forego state contribution.

Option 2 materials and forms are included in your initial benefit enrollment materials.

2. WHETHER TO ENROLL IN OPTIONAL BENEFITS

a. Optional Benefits Which Face Restrictions After the Initial Enrollment Period

A newly eligible employee who wants any of the following optional benefits must enroll in these benefits within 31 days of the first day of eligibility for coverage to be automatic. Enrollment in optional benefits must occur at the time of enrollment in core benefits to avoid Premium Payment Plan and Flexible Spending Account restrictions (see B.5 and B.6).

Affected Optional Benefits Are:

1) Medical (including the Prescription Drug Plan) and dental coverage for existing dependents.

After the initial enrollment period, you can only enroll dependents for medical coverage under certain circumstances (see B.3).

Dependents can be enrolled for dental coverage during any annual change period (or at any time if the subscriber is not on the Premium Payment Plan), but that requires an application signed by the dependent's dentist showing that all needed dental work has been completed and approval by the State Plan's claims administration company (see B.3).

2) Optional vision insurance. This is available only during the initial enrollment period and during an annual change period for any benefit year(s) the coverage is offered.

3) Plan B – basic dependent life insurance on existing dependents. This is only available later if you marry or have a first child.

4) Plan C – optional employee life insurance on self, in the amount of one times your annual salary rounded to the next highest $5,000. Later enrollment requires an application showing evidence of insurability, which must be accepted by the underwriting department of the State Plan's life insurance company.

5) Long-term care insurance on self (monthly benefit amounts of $1,000 – $4,000). A separate application is required, but dur-

ing the initial enrollment period, this application does not require approval. Later enrollment (or enrollment for monthly benefit amounts of $5,000 or $6,000) requires an application showing evidence of insurability, which must be accepted by the underwriting department of the State Plan's long-term care insurance company.

6) Flexible Spending Accounts (available to active employees who receive regular paychecks through Central Payroll — see B.6). This is not available again until the next annual change period unless there is a qualifying event as described in B.6.

b. Optional Benefits Which are Less Affected by Time of Enrollment

Whether enrollment occurs during the first 31-day initial enrollment period may not affect your ability to obtain the following benefits. However, once you have enrolled, you must wait until an annual change period to add or change benefits whose premiums are paid pre-tax through the Premium Payment Plan (see B.5).

1) Plan C – optional employee life insurance on yourself in excess of one times your annual salary rounded to a $5,000 increment. This coverage always requires application and approval by the State Plan's life insurance company.

2) Plan D – supplemental spouse life insurance. This coverage always requires application and approval by the State Plan's life insurance company.

3) Plan E – accidental death and dismemberment insurance. This coverage never requires application and approval by the State Plan's life insurance company.

4) Long-term care insurance on your spouse (or parents) or coverage on yourself for monthly benefit amounts of $5,000 or $6,000. These coverages always require application and approval by the State Plan's long-term care insurance company.

3. IF YOU ENROLL

On the first day you meet eligibility requirements and are employed in active pay status, you may enroll with your agency payroll personnel in core benefits for yourself, the subscriber (and the optional benefits listed below). When you sign the enrollment form, you authorize any premium costs (for core and any optional benefits you elect), which exceed the state contribution, to be deducted from your pay. See a current rate sheet for premium costs and the applicable state contribution.

When you enroll, you must:

a. choose a medical plan for the remainder of the benefit year; and

b. either accept automatic participation in the Premium Payment Plan or decline participation for the remainder of the benefit year (see B.5).

At that time, you may also elect any of the following optional benefits:

a. Medical and/or dental coverage for dependents (dependents must be on same medical plan as the subscriber).

b. Optional vision insurance.

c. Any optional life insurance on yourself and dependents which does not require approval of the State Plan's life insurance company.

d. Accidental death and dismemberment insurance.

e. Flexible Spending Accounts.

You may also apply for additional life insurance coverage on yourself (additional Plan C coverage), life insurance on your spouse (Plan D – supplemental spouse), and you, your spouse, parents, and parents-in-law may apply for long-term care insurance benefits.

You should elect any optional benefits and apply for additional Plan C life insurance at the same time you enroll in core benefits to avoid Premium Payment Plan and Flexible Spending Account restrictions (see provisions B.5 and B.6).

Elected officials become eligible to enroll on the first day they take the oath of office or the day the term begins, whichever comes first.

4. IF YOU WAIVE BENEFITS

If you waive State Plan coverage because you have coverage under another comparable plan, you do not give up your rights as an eligible state employee to automatic enrollment in core benefits at a later date. This automatic enrollment does not apply to dependents.

The one-year waiting period for prescription drug coverage described in C.5 and the waiting period for coverage of a pre-existing medical condition described in C.4 apply (just as they apply to employees who enroll during their first 31 days), unless you receive a previous coverage credit described in C.6.

5. RE-ENROLLMENT FOLLOWING TERMINATION

If a state employee who has terminated employment and State Plan benefits is rehired and re-enrolled in the State Plan within 30 days of termination, any prior coverage is reinstated. A former employee, who is rehired after 30 days, may make new plan elections and enroll any eligible dependents, the same as any newly hired employee. Any expenses incurred during a lapse in coverage are not covered regardless of whether the rehire is within 30 days of termination or later.

B.2 Enrollment of Newly Acquired Dependents During a 63-day Special Enrollment Period Triggered by a New-Dependent Qualifying Event

New dependents (a newly acquired spouse or child) must be enrolled (through your agency payroll personnel) within 63 days of the date on which they first became eligible (the qualifying event) in order to receive automatic medical and dental coverage and meet Premium Payment Plan change requirements. See C.2 for special newborn coverage. Documentation of the qualifying event (for example, a copy of the marriage license or birth certificate) is required at the time of enrollment.

Legally adopted children must be enrolled (through your agency payroll personnel) by providing copies of the court ordered adoption to the payroll person within 63 days of the date on which they first became eligible (date of adoption court order).

Pre-adoptive children must be enrolled (through your agency payroll personnel) by completing an affidavit of intent to adopt or providing placement agreement documents within 63 days of the date on which they first became eligible (date of pre-adoption placement agreement). Interim coverage for the pre-adoption placement period will be provided for a maximum of 14 months from the date of placement. (See C.2 for pre-adoptive coverage.)

In the case of a birth, adoption, or pre-adoptive placement, the spouse and other dependents of an employee may be enrolled along with the new dependent child during the child's 63-day special enrollment period.

IMPORTANT

New dependents not enrolled for medical coverage within their first 63-day special enrollment period may only be added later under certain circumstances (see B.3).

B.3 Other Qualifying Events Which Trigger 63-day Special Enrollment Periods for Dependents

An employee may elect not to enroll a dependent for medical and/or dental coverage within the employee's initial enrollment period (described in B.1) or within a newly-acquired dependent's special enrollment period (described in B.2) because the dependent has comparable coverage with another group plan or government program. In this case, the dependent can be enrolled for medical and/or dental benefits at a later date during a 63-day special enrollment period beginning on one of the following qualifying events:

1. Loss of other coverage due to loss of eligibility (not cancellation or failure to pay premiums) as a result of events such as spouse's termination or loss of employment; spouse's reduction in hours resulting in loss of eligibility for benefits; loss of eligibility for Medicaid, Medicare, CHIP, or other governmental health insurance benefits; or in the case of a dependent child, divorce resulting in loss of eligibility under the ex-spouse's plan.

2. A significant adverse change (benefit cuts and/or premium increase) in the other insurance plan as approved by the EBB.

   The one-year waiting period for prescription drug coverage (described in C.5) and the waiting period for coverage of a pre-existing medical condition (described in C.4) apply to the above — just as they apply to dependents enrolled in their first 31 days of eligibility — unless the eligible dependent receives a previous coverage credit described in C.6.

3. A child support order or change in a child support order, which makes a State Plan subscriber responsible for a dependent child's medical insurance.

RELATED INFORMATION – DEPENDENT DENTAL APPLICATION

Dependents can also be added to your dental coverage later through application approved by the State Plan's claims administration company. The dependent must have had a dental examination within six months of completing the application, and any required dental work must be completed as certified by your dependent's dentist. The application can only be submitted during an annual change period for the next benefit year if you are (a) in the Premium Payment Plan (see B.5) and (b) the dependent being added will change your dental premium.

B.4 Enrollment of Individuals Who Are Eligible Both as Employees and Dependents or Who Are Eligible Dependents of More Than One State Employee

Two spouses or a parent and child who are both employed by the state and who are both eligible employees must each enroll (or waive) core benefit coverage. One may not be enrolled as a dependent of the other, with the following exceptions in the case of spouses: Plan B – dependent life, Plan D – supplemental spouse coverage, and Plan E – accidental death and dismemberment (AD&D) insurance.

RELATED INFORMATION – FSAs

Qualified medical expenses of any FSA-eligible dependent (whether they have their own Flexible Spending Account or not) can be paid through a Medical Flexible Spending Account.

JOINT CORE COVERAGE

If two spouses who are both eligible employees have eligible dependents they wish to enroll, they may enroll for joint core coverage under the same medical plan. The children will be enrolled as dependents of one of the parent spouses, but with joint core coverage. Joint core coverage means that the spouses and children will have only one family deductible and one family out-of-pocket maximum to meet and may have a slightly lower premium rate than enrolling separately.

If the spouses choose to enroll separately, one spouse will have employee-only coverage and the other spouse will have employee and children coverage with separate deductibles and out-of-pocket maximums. The dependent children can only be covered as dependents of one of the spouses.

B.5 Premium Payment Plan Enrollment and Restrictions on Changes Affecting Premium Amount

1. PREMIUM PAYMENT PLAN

This is a plan for paying your share of insurance premiums with pre-tax dollars, rather than with after-tax dollars. It saves you tax dollars. The plan is offered in accordance with U.S. Internal Revenue Code (IRC) Section 125 and applicable federal regulations. Please note that you must participate in this program in order to participate in the Flexible Spending Account program (see B.6).

Premiums paid through the Premium Payment Plan cannot be claimed as medical expenses when calculating itemized deductions on your federal income tax return or when calculating the federal Earned Income Tax Credit. This credit is available to low-income families who pay premiums to insure one or more dependent children. Tax savings achieved by paying your premium through the Premium Payment Plan may be more favorable than those achieved by claiming them as a medical expense deduction because of limitations on medical expenses that can be claimed.

Employee contributions, which are eligible for pre-tax payment (deduction from gross wages), include contributions to:

a. medical, dental, and optional vision insurance (including dependent coverage);
b. up to $50,000 of term life insurance (plans A and C); and
c. accidental death and dismemberment (AD&D) insurance.

2. WHO MAY PARTICIPATE IN THE PREMIUM PAYMENT PLAN AND HOW TO ENROLL

All employees who enroll in the State Employee Benefit Plan are automatically covered by the Premium Payment Plan, unless they decline participation.

3. ANNUAL ELECTION

Once a year, during a designated annual change period, enrolled employees are asked to make the following elections for the upcoming benefit year:

a. whether they want to participate in the Premium Payment Plan;
b. what health plan they want for themselves and family members currently enrolled for medical benefits; and
c. what available optional benefits they wish to elect, change, or apply for.

This opportunity is provided in the fall of each year for the following benefit year beginning January 1.

4. MID-YEAR RESTRICTIONS ON CHANGES

Once a benefit year begins and the first premium has been taken, IRS regulations prohibit enrolled employees from joining or dropping out of the Premium Payment Plan or making benefit changes which affect the amount of premium paid with pre-tax dollars until the beginning of the next benefit year, with a few exceptions.

Pre-tax premiums may be changed mid-year under the following circumstances:

a. the employee elected to make the change during the annual change period before the benefit year started, but had to await application approval.

b. the change is automatically triggered by a change in age (age-based life insurance rates), salary (amount of Plan C life insurance coverage), or a general premium change authorized by the EBB.

c. a change in coverage and premium is needed (or enrollment in the Premium Payment Plan is needed) because of a qualifying event (a qualifying change in family/employment status).

Qualifying events include:

1) marriage.
2) divorce, legal separation, or a change in a custody/support order.
3) death of a spouse or child.
4) birth or adoption of a child.
5) employment change of a spouse, which affects his/her eligibility for benefits, such as termination, reduction or increase in hours, going on unpaid leave, etc.
6) a major change in a spouse's benefits: an adverse change (such as major increases in out-of-pocket premium costs, deductible, or copayment maximums) prompting dependent additions to your plan; or a positive change (such as added benefits or cost reductions) prompting dependents to be deleted from your State Plan and moved to your spouse's plan.
7) a dependent child's loss of eligibility under your plan (due to age, employment, marriage, military service, etc.) or loss of a dependent child's eligibility under your spouse's plan necessitating an addition to your plan.
8) Loss of other health benefits such as Medicaid, Medicare, or CHIP by a dependent.

Changes in coverage must be consistent with the qualifying event and requested within 63 days of the qualifying event. Permissible changes do not include a change in medical plans, unless you move out of the plan's service area or retire. Requests for permissible coverage changes and documentation of the qualifying event must be received (date stamped) at the EBB Office, Room 125 Mitchell Building, PO Box 200217, Helena, MT 59620; or received by fax at 444-3573 by the 63rd day. Changes involving a reduction in premium should be requested as soon as possible to avoid loss of premium dollars (see refund restrictions below) and liability for claims paid on an ineligible dependent (see A.4).

5. REFUND RESTRICTIONS

Internal Revenue Service codes prohibit refunds when changes are made to coverage that has been paid with pre-tax dollars. Employees on the Premium Payment Plan need to remove ineligible dependents as soon as

they become ineligible to avoid losing premium dollars by contacting the EBB at the above address or fax number.

6. CHANGES NOT SUBJECT TO MID-YEAR RESTRICTIONS

Allowable changes in coverage, which do not change the amount of premium paid with employee pre-tax dollars, can be made at any time. These include:

a. changes that do not affect premium (such as the addition of a second child to the Dental Plan); and
b. any changes in life insurance (plans A and C) from an amount over $50,000 to another amount over $50,000 (premium for life insurance amounts in excess of $50,000 must be paid after taxes).

7. RE-ENROLLMENT FOLLOWING TERMINATION

If a state employee who has terminated employment and State Plan benefits is rehired and re-enrolled in the State Plan within 30 days of termination, any prior coverage is reinstated as described in B.1, provision 5. Coverage paid pre-tax can only be changed during a benefit year if one of the qualifying events listed in provision 4 above has occurred. A former employee, who is rehired after 30 days may make new plan elections and enroll any eligible dependents, the same as any newly hired employee. Any expenses incurred during a lapse in coverage are not covered, regardless of whether the rehire is within 30 days of termination or later.

B.6 Flexible Spending Account (FSA) Enrollment and Changes

1. FLEXIBLE SPENDING ACCOUNTS

a. Medical FSA

A medical FSA is an IRS approved way for enrolled employees to pay for their own or a family member's eligible medical expenses that are not covered by insurance on a pre-tax basis. (Eligible expenses of family members who are not on the State Plan can be paid through an FSA. See Chapter 6 for eligible medical expenses).

b. Dependent Care FSA

A dependent care FSA is an IRS approved way to pay for qualified dependent care (day care) expenses on a pre-tax basis. See Chapter 6 for a listing of eligible dependent care expenses.

FSAs are offered in accordance with U.S. Internal Revenue Code (IRC) Sections 125 and 129 and applicable federal regulations and save you tax dollars on eligible expenses.

c. Relationship to Tax Deductions & Credits

Medical expenses submitted for reimbursement through a Medical FSA cannot be claimed as medical expenses when calculating itemized deductions on your federal income tax return. Tax savings achieved by paying your medical expenses through an FSA may be more favorable than those achieved by claiming them as a medical expense deduction, because of limitations on medical expenses that can be claimed.

Dependent care expenses submitted for reimbursement from a Dependent Care FSA cannot be used to calculate the dependent care credit on your federal income tax return. The amount eligible for the tax credit is directly reduced by the amount placed in a Dependent Care FSA. Tax savings from an FSA may be greater or less than taxes saved by using the Child Care Tax Credit. Call or visit the web site of the State Plan's FSA administration company to assist you in deciding between these two options.

2. WHO MAY PARTICIPATE IN AN FSA AND HOW TO ENROLL

Employees who are enrolled or are in the process of enrolling in the State Plan, and who are paid through the Central State Payroll System, are eligible to enroll in both the Medical and Dependent Care FSAs.

New employees who want an FSA must enroll in the FSA program within their first 31 days as described in B.1. All employees in the State Plan may enroll in one or both FSAs each year as described in B.6, provision 5, below.

3. HOW MUCH CAN BE PUT INTO EACH ACCOUNT?

You may put up to $5,000 of pre-tax dollars into your Medical FSA per benefit year, and in most instances,

up to $5,000 of pre-tax dollars into your Dependent Care FSA. IRS regulations change this $5,000 dependent care maximum if any of the following apply:

a. If your spouse is also enrolled in a Dependent Care FSA, your total annual family contribution cannot exceed $5,000.

b. If either you or your spouse earns less than $5,000 a year, you can contribute up to the lower of the two incomes.

c. If your spouse is either a full-time student or incapable of self-care, you may contribute up to $3,000 a year for one dependent or $5,000 a year for two or more dependents.

d. If you are married but file a separate federal income tax return, you may put a maximum of $2,500 into your Dependent Care FSA.

The minimum you may put into each account is $120 per year, or $10 per month.

4. PLACING UNUSED MONTHLY STATE CONTRIBUTION INTO AN FSA

Any portion of the state contribution in excess of the amount needed for core benefits and any elected optional benefits, will be placed in an FSA, provided you are enrolled in an FSA and designate the amount.

5. ANNUAL ELECTIONS

Once a year, during the annual change period, you must decide whether you wish to participate in one or both Flexible Spending Accounts and elect the amount of pre-tax dollars you wish to put into the account(s) for the next benefit year. This annual amount is then divided into equal pay-period amounts, which are deducted first from any unused state contribution and then from gross pay. An administrative fee for FSA administration services is also deducted from your gross pay.

An expense must be incurred (services received or products ordered) during the benefit year in which an FSA is in effect to be reimbursable from that FSA (as described in I.3). This may or may not be the same time you are billed for and pay for the services or products. If you are planning to pay for services that are received over the course of more than one benefit year through an FSA (especially orthodontia), contact the FSA program administrator in advance of making your FSA election for assistance.

6. MID-YEAR RESTRICTIONS ON CHANGES

Once the new benefit year has begun and the first payroll has run, you may not change or discontinue your election for the remainder of the benefit year, unless a change is needed due to a qualifying change in family or employment status. Qualifying events are the same as for the Premium Payment Plan (see B.5, provision 4).

To make a change, you must submit a change form (available from your agency payroll personnel) to the EBB within 63 days of the qualifying event. Mid-year reductions in Medical FSAs are not allowed if you have already received more in reimbursements than you have contributed

7. USE IT OR LOSE IT REQUIREMENT

If, at the end of the benefit year, you have not had enough eligible expenses to use up your FSA amount, you forfeit the unused balance. IRS rules do not allow refunds or carry over of unused balances into the next year, or moving funds from one FSA (medical) to another (dependent care). It is important to put no more of your gross salary dollars into an FSA than you are sure you will use during the year.

8. RE-ENROLLMENT FOLLOWING TERMINATION

If a state employee who has terminated employment and State Plan benefits is rehired and re-enrolled in the State Plan within 30 days of termination, any prior FSA enrollment is reinstated at prior monthly contribution rates. The annual FSA election will be reduced by the amount of any missing contributions and no expenses incurred during the lapsed period of coverage are eligible for FSA reimbursement. The FSA annual election and monthly contribution can only be changed if one of the qualifying events listed in B.5, provision 4, has occurred. A terminated employee, who is rehired after 30 days, may make a new FSA election, the same as any newly hired employee, and only expenses incurred after the effective date of the newly-elected FSA are eligible for reimbursement from that account.

C. WHEN COVERAGE BEGINS

C.1 For Newly-Hired and Newly-Eligible Employees (and Their Dependents) Enrolled Within the 31-Day Initial Enrollment Period

1. CORE EMPLOYEE MEDICAL AND DENTAL INSURANCE COVERAGE MAY BE MADE EFFECTIVE ON:

a. the first day of the pay period following receipt of enrollment forms by the EBB; or
b. retroactive back to the first day of employment for new hires and the first day of eligibility for newly-eligible employees, provided:
    1) an enrollment form is submitted within the 31-day initial enrollment period; and
    2) the enrollment form authorizes a payroll deduction of any retroactive premium due. Retroactive premium must be taken after taxes, regardless of whether you will be on the Premium Payment Plan, to comply with Internal Revenue Service requirements.

To make sure you receive the most favorable benefits for early medical expenses, select your medical plan early and follow any plan rules regarding eligible providers, referrals, etc. (See C.4 for coverage effective dates on pre-existing medical and dental conditions, and C.5 for prescription drug coverage effective dates.)

2. OPTIONAL DEPENDENT MEDICAL AND DENTAL INSURANCE

Optional dependent medical and dental insurance coverage is effective on the same date as employee medical and dental insurance. Coverage of pre-existing conditions and prescription drugs may be delayed as described in C.4, C.5, and C.6.

3. OPTIONAL VISION INSURANCE

Optional vision insurance coverage is also effective on the same date as employee medical and dental insurance.

4. FLEXIBLE SPENDING ACCOUNTS

FSA coverage is effective the first day of the first month following enrollment in which a full month of FSA payroll deductions can be taken.

5. LIFE AND AD&D INSURANCE

Life and AD&D insurance coverages, which do not require application and approval by the State Plan's life insurance company, are effective on the same day as employee medical and dental coverage as described above. Elected optional life insurance benefits, which require approval, are effective on the first of the month following approval.

6. LONG-TERM CARE INSURANCE

Long-term care insurance benefits that do not require approval are generally effective on the first of the month following receipt of the application by the State Plan's long-term care insurance company if the application is received by the 15th of a month. Benefits are effective on the first of the second month following receipt of the application, if it is received after the 15th of a month.

Long-term care insurance benefits that require approval are effective on the effective date specified by the State Plan's long-term care insurance company.

C.2 For Later Dependent Enrollments Triggered by a Qualifying Event

The effective date of medical and dental insurance is the beginning of the first day of the first pay period following EBB receipt of the enrollment form and documentation of the qualifying event — except in the case of birth, adoption, placement for adoption, and court ordered coverage described below. See C.4, C.5, and C.6 for waiting periods for coverage of pre-existing conditions and prescription drugs.

Since enrollment forms and any required documentation must be received before coverage can begin, it is important to enroll dependents as soon as they become eligible or a qualifying event occurs. Waiting until the

end of the 63-day special enrollment period delays coverage.

1. BIRTHS

Automatic medical coverage of an infant born to a plan member begins at birth for a 31-day period. You must submit an Enrollment/Change Form (no later than 63 days after the birth) and make any required employee contributions to continue medical coverage on an eligible newborn dependent beyond the first 31 days. You may also enroll the newborn for dental coverage at that time or wait until later (Dental Plan enrollment of a child under the age of 3 does not require application and approval). Retroactive medical coverage back to the date of birth may be obtained for an eligible newborn dependent (as well as the spouse and other eligible dependents) if:

a. enrollment occurs within the 63-day special enrollment period; and
b. the enrollment form authorizes a payroll deduction of any retroactive premium due, which will be taken pre-tax for Premium Payment Plan members, as allowed by IRS rules.

2. ADOPTION AND PRE-ADOPTIVE PLACEMENT

Medical and dental coverage of a child adopted by (or placed for adoption with) a subscriber or subscriber's spouse can begin on the date of the adoption or pre-adoptive placement agreement, if:

a. the adoption court order or Affidavit of Intent to Adopt has been completed;
b. enrollment occurs within the 63-day special enrollment period; and
c. the enrollment form authorizes a payroll deduction of any retroactive premium due, which will be taken pre-tax for Premium Payment Plan members as allowed by IRS rules.

Copies of the adoption court order or pre-adoptive placement agreement are required. Coverage for pre-adoptive placement will be provided for a maximum of 14 months from the date of placement.

3. COURT ORDERED COVERAGE

Medical and dental coverage of a child subject to a court order can begin on the date of the order, if:

a. enrollment occurs within the 63-day special enrollment period (63 days of the effective date of the order); and
b. the enrollment form authorizes a payroll deduction of any retroactive premium due.

In the case of court ordered coverage, enrollments will be accepted after the 63-day special enrollment period, but coverage is effective the first day of the first pay period following EBB receipt of the enrollment form and documentation of the qualifying event (court order).

4. THE EFFECTIVE DATE FOR OTHER (NON-MEDICAL) INSURANCE BENEFITS

The effective date for insurance coverages that do not require application and approval is the beginning of the first day of the first pay period following EBB receipt of the enrollment form and required documentation of the qualifying event. The effective date for a Flexible Spending Account is always the first day of the month following enrollment, in which a full month of FSA payroll deductions can be taken. The effective date for optional benefits, which require application and approval, is the first of the month following approval, or in the case of long-term care insurance, the effective date is set by the long-term care insurance company.

C.3 For Later Enrollment in Employee-Only Coverage by Employees Who Initially Waived Coverage

The effective date is the beginning of the first day of the first pay period following EBB receipt of the enrollment form. See C.4, C.5, and C.6 for waiting periods for coverage of pre-existing conditions and prescription drugs. Dependents may not be added without a qualifying event outlined in B.1, B.2, and B.3.

C.4 Waiting Periods for Pre-Existing Conditions

Medical and Dental Plan coverage (excluding prescription drug coverage) of any pre-existing medical or dental condition is available only after a new member has been continuously covered for a period of 12 consecutive months, except as provided in C.6. See C.5 for the waiting period for prescription drug benefits.

A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment (including prescrip-

tion drugs) was recommended or received within the six-month period prior to the enrollment date. Pregnancy and any conditions of an eligible dependent newborn, an eligible dependent child being adopted, or a child added through a child support order are not pre-existing conditions.

In the event an employee or dependent is already hospitalized on the date he or she wished to enroll for coverage, enrollment will be deferred until the day following the day of termination of such hospital confinement (unless a previous coverage credit is granted as provided in C.6).

RELATED INFORMATION

Type C Dental Services

Coverage of Type C dental services (for example, inlays, crowns, gold fillings, initial dentures, and repair dentures) does not begin until after 12 months of continuous Dental Plan coverage. Coverage of replacement dentures does not begin until after 36 months of continuous Dental Plan coverage unless a previous coverage credit is granted under C.6.

Long-Term Care Insurance

Long-term care insurance excludes coverage of a pre-existing condition when coverage was obtained without submitting evidence of insurability. See the pre-existing condition exclusion in the long-term care insurance outline of coverage.

C.5 Waiting Period for Prescription Drug Benefits

Prescription drug benefits do not begin until after 12 months of continuous state plan coverage, except for newborn, newly adopted dependents, or a child support order.

This waiting period on all prescription drug benefits will be shortened by any creditable coverage, just as the waiting period for medical plan coverage of a pre-existing condition is shortened by creditable coverage, as described in C.6.

C.6 Creditable Coverage

Any period of up to 12 months of prior comprehensive medical coverage on a new State Plan enrollee, defined as creditable coverage in Chapter 9, will be credited toward:

a. the 12-month waiting period on a pre-existing medical condition described in C.4; and
b. the 12-month waiting period on Prescription Drug Plan benefits described in C.5 (provided the creditable coverage included prescription drug benefits).

Any period of up to 12 months of creditable dental coverage on a new State Plan enrollee will be credited toward the 12-month waiting period on a pre-existing dental condition (and toward the 36-month waiting period on replacement dentures).

Only prior coverage since the last 63-day break in coverage, which satisfies the definition of creditable coverage, will be credited toward waiting periods. A certificate of creditable coverage from the prior plan must be submitted to the EBB and approved.

EXAMPLE

If a newly enrolled employee or dependent was previously insured by another comprehensive group health plan for a year or more without a lapse between the prior and State Plan coverage of more than 63 days, 12 months of creditable coverage is applied, eliminating any waiting period on a pre-existing medical condition. If the employee or dependent was only previously covered for five months, five months of the 12-month waiting period would be eliminated, leaving a seven-month waiting period.

If the former plan did not include a significant benefit (such as an organ transplant benefit) or only included a limited benefit, credit may be denied for the missing benefit or portion of benefit. In the case of a limited benefit under the former plan, State Plan coverage for the first 12 months of membership would be limited to the benefit of the prior plan.

D. WHEN COVERAGE ENDS

D.1 Medical and Dental Benefits

EMPLOYEE COVERAGE ENDING DATE

Coverage of an enrolled employee (and his or her dependents) ends (except as provided in Section E) at 12:00 midnight on the last day of the month or pay period (as established by the EBB) in which one of the following occurs:

1. The employee's state employment terminates, or the employee otherwise ceases to be eligible under the State Employee Benefit Plan.
2. Premium due is not paid.
3. The State Plan terminates.

Terminating employees who have been continuously covered by the State Employee Benefit Plan since August 1, 1998 (when advance premium collection ended), are entitled to an additional month or two additional pay periods of coverage for themselves and their dependents (as established by the EBB) provided any required employee contribution is paid.

DEPENDENT COVERAGE ENDING DATE

Coverage of an enrolled dependent also ends (except as provided in Section E) at 12:00 midnight on the last day of the month or pay period (as established by the EBB), in which the dependent ceases to meet State Plan eligibility requirements.

It is the employee's/subscriber's obligation to notify agency payroll personnel within 31 days when a dependent becomes ineligible for benefits. Premium Payment Plan members should provide notification as early as possible to avoid making unusable and nonrefundable payments (see B.5, provision 5). Coverage of dependents turning age 25 should automatically terminate. However, if it does not, it is the employee's responsibility to notify the EBB of the dependent's loss of eligibility.

D.2 Other Benefits

Group life insurance, accidental death and dismemberment insurance, long-term care insurance benefits, and optional vision insurance end when medical and dental benefits end (except as provided in Section E). Optional vision, life, and AD&D insurance coverage also cease when the group policies providing these coverages cease, although similar benefits may be continued through another insurance company or self-insurance by the state. Flexible Spending Account coverage ends (except as provided in Section E) at the end of the month in which the last employee contribution is taken.

E. COVERAGE CONTINUATION RIGHTS

E.1 Employee and Dependent Plan Members Losing Eligibility – COBRA and State Employee Protection Act Rights

This provision summarizes your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1986, commonly referred to as COBRA (Public Law 99-272, Title X), and the State Employee Protection Act (2-18-1201 MCA). See E.2 and E.3 for rights during a leave without pay and leave involving workers compensation benefits. See Section F for additional rights to convert some group insurance benefits to an individual or conversion policy.

1. LAID OFF EMPLOYEES — STATE EMPLOYEE PROTECTION ACT COVERAGE

Under the State Employee Protection Act, an employee who is laid off as part of a reduction in force covered by the Act, may continue existing State Plan coverage for six months from the effective date of the layoff, or until the employee becomes employed in a job that provides comparable insurance benefits, whichever comes first. During this time the employee receives state contribution toward the cost of premiums and must only self pay the employee contribution.

2. EMPLOYEE RIGHTS TO COBRA COVERAGE

Under COBRA, an employee covered by the State Plan may continue existing State Plan medical, dental, and optional vision coverage on him or herself and/or dependents (see E.1, provision 4) if coverage would otherwise be lost due to any of the following qualifying events:

a. Layoff or reduction-in-force (COBRA coverage starts after any period of State Employee Protection Act coverage ends).

b. Voluntary termination of employment for reasons other than gross misconduct.

c. Voluntary or involuntary reduction in scheduled hours below 20 per week.

To continue coverage under COBRA, you must self-pay the entire applicable monthly premium.

Employees covered by the State Plan whose hours are reduced as a result of leave of absence or any injury for which Workers' Compensation benefits are being received have other rights to continue coverage which must be exhausted before COBRA rights are available (see E.2 and E.3).

FSA Coverage Continuation

An employee with any of the above events may continue a Flexible Spending Account (FSA) through the remainder of the benefit year through one of two payment options:

a. by making as many of the remaining monthly FSA contributions for the benefit year as can be taken out of the final pay check on a pre-tax basis (to receive the tax benefit) and self-paying for any remaining months with after-tax dollars at the beginning of each remaining month; or

b. by self-paying the FSA contribution for all post-employment months with after-tax dollars at the beginning of each month.

Continuation Period

COBRA medical, dental, and optional vision coverage may be continued for up to 18 months. Flexible Spending Account participation may be continued through the remainder of the current benefit year.

Disability Continuation Period

COBRA coverage may be continued for up to 29 months if an employee enrolled in the State Plan is determined to have been disabled under the Old Age, Survivors, and Disability Insurance (OASDI), or Supplemental Security Insurance (SSI) of the Social Security Act at the time of, or within 60 days after, the pertinent qualifying event described above. The employee must apply to the EBB (444-3871) for the extended coverage during the first 18 months of COBRA coverage, and within 60 days after the date of the disability determination by the Social Security Administration. Flexible Spending Accounts may also be continued through the remainder of the current benefit year (see E.1, provision 4).

3. DEPENDENT RIGHTS TO COBRA COVERAGE

Independently of the employee, the spouse or other dependent of a state employee enrolled in the State Plan, who self-pays the entire applicable monthly premium, may continue existing medical, dental, and optional vision coverage (see E.1, provision 4) if coverage would otherwise be lost due to any of the following events:

a. the death of the employee and the spouse or dependent is not eligible for, or does not exercise rights outlined in E.7.

b. the lay-off, reduction-in-force, voluntary or involuntary termination (for reasons other than gross misconduct), or reduction in hours of employment of the employee.

c. divorce, legal separation, or removal of a spouse from the plan in anticipation of divorce.

d. attainment of age 25 by a dependent child or some other event resulting in loss of dependent status.

Continuation Period

Except where coverage is lost as result of the employee's loss of eligibility due to layoff, termination, reduction in hours, etc., COBRA medical, dental, and optional vision coverage may be continued for up to 36 months. (Surviving dependents eligible to continue coverage under E.7 must exhaust their rights under that provision before COBRA rights are available.) Coverage lost due to layoff, termination, reduction-in-hours, etc., may be continued for only up to 18 months, absent a qualifying disability described below. Flexible Spending Account participation may be continued through the remainder of the current benefit year.

Disability Continuation Period

Coverage may be continued for up to 29 months for a covered dependent with a qualifying disability at the time of, or within 60 days after the employee's layoff, reduction-in-force, or voluntary/involuntary termination. The disability must qualify under the Old Age Survivors and Disability Insurance (OASDI) or Supplemental Security Income (SSI) sections of the Social Security Act as determined by the Social Security Administration. To receive the COBRA extension, a copy of your SSI determination must be filed with the EBB within the first 18 months of COBRA coverage and within 60 days after the date of the disability determination of the Social Security Administration. Flexible Spending Account participation may be continued through the remainder of the current benefit year.

Impact of a Second Qualifying Event on the Continuation Period

If a dependent on a COBRA subscriber's coverage or a newly acquired dependent added to a COBRA subscriber's coverage loses eligibility due to another qualifying event (such as a child turning age 25), the dependent has an independent right to continue coverage for 36 months from the date of the original qualifying event. If an employee, who has continued Sate Plan insurance under COBRA for up to 18 months, becomes entitled to Medicare during that time, COBRA coverage for qualified covered dependents may be extended for up to 36 months from the original qualifying event.

4. COBRA CONTINUATION OPTIONS

COBRA-eligible employees may continue the following existing insurance coverage combinations on themselves and covered dependents:

a. medical insurance only.

b. medical, plus dental insurance.

c. medical, plus optional vision insurance.

d. medical, plus dental, plus optional vision insurance.

Dependents may also independently continue any one of the above coverage combinations, provided the coverage was in effect before the event resulting in loss of eligibility (and provided they are not covered as a dependent of COBRA-eligible employee). Only those dependents with dental and/or optional vision coverage — but no medical coverage — before the event resulting in loss of eligibility, may continue dental and/or optional vision coverage without continuing medical coverage. COBRA-eligible dependents who had medical coverage and wish to add dental must submit evidence of insurability and receive approval. Optional vision can only be added at annual change for any benefit year it is offered.

Flexible Spending Accounts can also be continued through the end of the benefit year. No life, accidental death and dismemberment, or long-term care insur-

ance benefits may be continued under this provision. New dependents may be added for the same coverage as the employee or COBRA-continuing dependent, provided they are enrolled as specified in B.2

5. COBRA CONTINUATION PROCEDURES

For loss of dependent eligibility due to divorce, attainment of age 25, or other event, the dependent must notify the EBB of the event within 60 days of the event, or the date on which coverage terminates due to the event, whichever is later. *The right to continue coverage is forfeited if the EBB is not notified within the 60-day time period.*

When the EBB receives notice of loss of dependent status, a Second Notice of COBRA Rights is sent (employees and enrolled dependents receive the first notice within three months when they first enroll). In the case of dependents turning age 25, the State Plan's claims administration company normally sends an automatic notice of COBRA rights. However, it is your, or your dependent's, responsibility to notify the EBB of loss of dependent eligibility if you do not receive a notice.

An automatic second notice of COBRA rights is also sent when covered employees terminate employment with the state or otherwise lose eligibility for State Plan benefits.

You and/or your dependents must elect to continue coverage under COBRA within 60 days of the latter of:

a. the date you receive your COBRA Rights Notice; or
b. the date active employee coverage ends.

The right to continue coverage is forfeited if not exercised within this 60-day period. All back premiums (premiums for intervening months since coverage was lost) must be paid within 45 days of the date you elect to continue coverage.

6. TERMINATION OF COBRA COVERAGE

COBRA coverage terminates before the end of the normal continuation period if any of the following occurs:

a. the monthly premium is not paid by the first of the month of coverage or within the following 30-day grace period.

b. the COBRA member becomes eligible for Medicare.

c. the COBRA member, through employment, marriage, or some other means, becomes covered under another group plan. If the other group plan has a pre-existing condition waiting period, COBRA coverage terminates when that waiting period ends.

E.2 EMPLOYEES TAKING LEAVE OF ABSENCE

1. COVERAGE CONTINUATION OPTIONS

An employee enrolled in the State Plan, who is on an approved leave of absence without pay, may continue core benefits only or has the option of also continuing any or all optional benefits in effect before the leave for a period of up to 12 months. The employee will be responsible for paying the entire monthly premium, except for months of leave for which state contribution is required by:

a. Union contract.

b. The Federal Family Medical Leave Act (FMLA), which provides up to 12 weeks of state contribution for eligible family and medical leave.

All coverage ends when premium due is not paid, except that employees on FMLA leave may continue coverage for the period of FMLA leave by self-paying while on leave or by pre-paying prior to going on leave.

When coverage under this leave of absence provision ends, the employee and/or covered dependents may elect to continue medical and dental coverage under COBRA (see E.1).

An employee enrolled in a Flexible Spending Account may continue the account by paying elected FSA amounts in advance out of final pay check(s) (to receive a tax advantage) for a leave of known duration, by paying on an after-tax basis at the beginning of each month, or through a combination of these methods. If payments cease, the account becomes inactive, allowing only those funds accumulated before payment ended to be used for reimbursement of eligible expenses incurred before payment ended.

2. RE-ENROLLMENT FOLLOWING A LAPSE

If an employee allows State Plan coverage to lapse while on leave of absence and later returns to active employment, re-enrollment is as follows:

a. Medical, Dental, and Optional Vision Insurance

If the employee returns to work and re-enrolls in State Plan coverage within the same benefit year, any prior coverage is reinstated (assuming previously enrolled dependents continue to be eligible). A mid-year change in medical plans is not allowed (unless you move out of your elected plan's service area or retire) and no dependents, who were not formerly covered, may be added unless a qualifying event described in B.2 or B.3 has occurred during the lapse that would have triggered a special enrollment period. Other mid-year changes may be made for employees previously in the Premium Payment Plan only if one of the qualifying events listed in B.5, provision 4, has occurred.

If coverage lapses for more than 63 days, a new waiting period will be required for a pre-existing condition (medical and dental) and for prescription drug coverage, unless eliminated or reduced by creditable coverage as described in C.6.

b. Flexible Spending Accounts

If the employee returns to work and re-enrolls in the State Plan within the same benefit year, any prior FSA enrollment is reinstated under one of two employee options:

1) coverage is resumed at the original annual amount and any missing contributions are made up by increasing the remaining monthly contributions.

2) coverage is resumed at an annual amount reduced by the amount of the missing contributions.

No expenses incurred during the lapsed period of coverage are eligible for FSA reimbursement. The FSA annual election and monthly contribution can only be changed if one of the qualifying events listed in B.5, provision 4, has occurred.

c. Life Insurance

Upon return to work, enrollment in basic Plan A (core life insurance) is required and Plan B (supplemental dependent life) is not available regardless of the period of time coverage has lapsed. Plans C (optional employee life) and D (optional dependent life) require application and approval if coverage has lapsed for a period of four months or more.

Life Insurance for an Employee Who Returns From an FMLA Leave

If the return is within FMLA time frames, any life insurance in effect at the time of the FMLA leave may be reinstated.

D. Long-Term Care Insurance

Re-enrollment requires application and approval by the State Plan's long-term care insurance company and rates are set at your or a re-enrolling spouse's age at time of re-enrollment.

E.3 Employees Receiving Workers' Compensation

An employee on the State Plan receiving Workers' Compensation benefits for any injury or illness sustained during state employment may continue core benefits and has the option of continuing any optional benefits in effect before the injury by self-paying the entire monthly premium. Coverage may be continued for as long as Workers' Compensation benefits are received and the individual's employment has not been terminated, but not to exceed 12 months. When coverage under this provision ends, the employee and/or covered dependents may elect to continue medical and dental coverage under COBRA (see E.1). Flexible Spending Accounts are continued as described in E.2.

If the employee allows coverage to lapse while on leave due to a work-related injury and later returns to active employment, re-enrollment is as described in E.2

E.4 Employees Who Become Totally Disabled

1. CONTINUATION OF LIFE INSURANCE AND PREMIUM WAIVER

An employee enrolled in the State Plan, who becomes totally and permanently disabled before the age of 60, may be eligible to continue some life insurance coverage under the State Employee Benefit Plan to age 65 without further payment of premium. A waiver of premium claim must be filed and required documentation submitted to the State Plan's life insurance company within 12 months of the date you stopped active work. If you become totally and permanently disabled, please contact the EBB for more information.

2. CONTINUATION OF LONG-TERM CARE INSURANCE AND PREMIUM WAIVER

When Long-Term Care Insurance Plan benefits become payable to a covered individual, premium is waived for as long as the individual continues to be eligible for a monthly benefit. Premiums are not waived while receiving payment for respite care. Respite care is formal care provided for a short period of time to allow the informal care giver a break from their care-giving responsibilities.

E.5 Employees and Their Dependents Who Become Medicare Eligible

Covered employees and their dependents who become Medicare eligible because they are turning age 65, or because of a disability other than End Stage Renal Disease, have the following options:

1. You or a dependent enrolled in the State Plan who becomes Medicare eligible may continue State Plan coverage only and not enroll for Medicare until you retire or terminate employment. Please note that there are Medicare premium penalties if you or your dependent fail to enroll in Part B Medicare during a short enrollment window at the time of retirement or termination of employment.
2. You may cancel State Plan coverage for you (which would cancel your state contribution toward benefits) and/or your dependent and rely on Medicare coverage. If your dependent is eligible for Medicare because of a disability, and loses Medicare eligibility in the future, that loss is a qualifying event allowing you to put your dependent back on the State Plan within 63 days of the loss.
3. You may continue State Plan benefits and enroll in Medicare benefits. In this case, the State Plan will be primary payer (see S.3).

END STAGE RENAL DISEASE

A State Plan member who is eligible to enroll in Medicare due to End Stage Renal Disease should enroll in Medicare (both parts) when first eligible (select option 2 or 3 above). The State Plan will cover End Stage Renal Disease as the primary payer for 30 – 33 months (depending on circumstances as required by Medicare's coordination period rules). After that time, Medicare becomes the primary payer, the State Plan becomes the secondary payer, and you may be eligible for a lower Medicare carve-out premium, provided the Medicare enrollment was timely (at the onset of Medicare eligibility).

E.6 Retirees

1. ELIGIBILITY, ENROLLMENT, AND PAYMENT

An employee enrolled in the State Plan who:

a. is eligible to draw a state retirement benefit at the time he or she leaves active state employment; and
b. makes arrangements with the EBB within 60 days of the date active employee coverage ends to continue post-retirement coverage,

may continue with the state group on a self-pay basis, retroactive back to the date active employee coverage was lost, as provided below.

Employees enrolled in the Premium Payment Plan may pre-pay eligible retiree premiums for up to the remainder of the benefit year from their final check on a pre-tax basis, provided a pre-payment request is timely submitted. Contact your agency payroll staff or the EBB. All information must be submitted by the end of the final pay period. Payment options for those who choose not to pre-pay, or when pre-payment ends, include:

a. automatic deduction from state retirement benefits (preferred);
b. electronic premium deduction from a checking or savings account; or
c. monthly self-payment.

The state contribution ends when active employee coverage ends. Premiums for converted coverages, described in Section F, are always self-paid directly to the applicable insurance company. *If state plan coverage is allowed to lapse or is cancelled at the time of or after retirement, no reinstatement in coverage is allowed.*

2. OPTIONS OF RETIREES WHO ARE UNDER AGE 65 AND NOT MEDICARE ELIGIBLE

At retirement, you are eligible to continue core benefits – medical, dental, and Plan A life insurance – on yourself. (See a current retiree packet for medical plan options. The medical plan may be changed at retirement provided the change is to a plan with the same or higher deductible.)

Retirees who continue core benefits may also continue:

a. existing medical and dental insurance on dependents (dependents must be on the same plan as the retiree); and
b. existing optional vision insurance.

You may also add eligible dependents to your Dental Plan each annual change period by submitting an evidence of insurability application for any dependents over the age of 3. Applications must be approved by the State Plan's claims administration company. Newly acquired dependents may be added in the same manner as newly acquired dependents of employees described in B.3. Dependents may be enrolled in optional vision insurance during the annual change period for any benefit year(s) in which optional vision is offered.

You are not eligible for optional group life or accidental death and dismemberment benefits. See Section F for rights to convert life insurance to an individual policy at higher rates and to convert any long-term care insurance to an individual policy at the same rates.

3. OPTIONS OF RETIREES WHO ARE OVER AGE 65 OR OTHERWISE MEDICARE ELIGIBLE

If you are over age 65 or already receiving Medicare benefits at retirement (or at the time you turn age 65 or become eligible for Medicare after retirement), you are eligible to continue:

a. medical insurance only on yourself; or
b. medical and dental coverage on yourself. (See a current retiree packet for medical plan options. The medical plan can be changed at retirement. The new medical plan must have the same or a higher deductible.)

Retirees who continue medical coverage on themselves may continue:

a. existing medical and dental insurance coverage on dependents (dependents must be on the same plan as the retiree); and
b. existing optional vision coverage.

You are not eligible for any group life or accidental death and dismemberment insurance benefits. See Section F for rights to convert life insurance to an individual policy at higher rates and to convert any long-term care insurance to an individual policy at the same rates.

At age 65, or at any time you or a spouse covered by the State Plan becomes Medicare eligible, you are eligible for a lower Medicare carve-out premium, provided you show proof of enrollment in both parts A and B of Medicare. To avoid a Medicare premium penalty, it is important to enroll yourself (if Medicare eligible) and/or a covered Medicare-eligible spouse in Part B Medicare as soon as you retire. If you, or a covered spouse, become Medicare eligible after you retire, enroll as soon as you/your spouse become Medicare eligible to avoid the premium penalty (and a Medicare late enrollment penalty).

4. TRANSFER OPTIONS

A retiree may transfer coverage and become a dependent of an actively employed or retired spouse on the State Plan or University System Plan, while still retaining the right to return to coverage under his or her own name in the case of an event resulting in loss of eligibility for spousal coverage (divorce, death of the spouse, etc.). A retiree who transfers onto the coverage of an employee or retiree spouse does not have to begin a new deductible or out-of-pocket maximum calculation, unless the dependent was on a different medical plan from the spouse.

E.7 Surviving Dependents

1. SURVIVING SPOUSE AND SURVIVING CHILDREN

A surviving spouse (or surviving child) of a deceased State Plan subscriber may continue:

a. existing medical only on self; or
b. medical and dental coverage on self. (The medical plan can be changed when surviving dependent coverage is elected. The new medical plan must have the same or a higher deductible.)

Surviving spouses who continue medical coverage on themselves, may also continue:

a. existing medical and/or existing dental coverage on dependents (dependents must be on the same medical plan as the surviving spouse subscriber); and
b. existing optional vision coverage.

A spouse may elect to continue coverage for as long as he/she is not remarried, in active military service, or employed, and by virtue of that event becomes eligible to participate in another group plan with equivalent benefits and costs.

Surviving children may continue coverage for as long as they have no equivalent medical coverage and are not eligible for medical insurance by virtue of the employment of a surviving parent, legal guardian, or spouse until age 25.

A surviving dependent must elect to continue coverage within 60 days of loss of coverage under the deceased subscriber and pay any retroactive premium required for continuous coverage in order to receive continued benefits under this provision.

Only those dependents of a subscriber covered by the State Plan at the time of the subscriber's death are eligible for continuation with the State Plan. Newly acquired dependents of a surviving spouse or another surviving dependent are not eligible for State Plan coverage.

(Surviving dependents are eligible to continue coverage under E.1 when this benefit is exhausted). A surviving spouse on the state Long-Term Care Insurance Plan may convert to an individual policy at the same rates (see Section F).

E.8 Legislators and Judges

1. LEAVING OFFICE

A legislator or judge leaving office, who does not qualify for continuation with the State Plan as a retiree under E.6, may continue core benefits (medical, dental, and core life) plus any existing dependent medical and dental coverage and any existing optional vision coverage until Medicare eligible as provided by 2-18-704 MCA.

To be eligible, the legislator or judge must:

a. terminate legislative/judicial service;
b. be a vested member of a legally constituted state retirement system; and
c. notify the EBB in writing within 90 days of the end of service.

The entire monthly premium must be paid by the legislator or judge.

A former legislator or judge may not continue State Plan coverage under this provision if the legislator or judge:

a. is a member of another plan with substantially the same or greater benefits at an equivalent cost; or
b. is employed, and by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

A former legislator or judge who continues on the State Plan under these provisions, and subsequently terminates coverage may not rejoin the plan unless he/she again serves as a legislator or becomes eligible through active state employment.

2. TERM LIMITED

A legislator who is involuntarily terminated because of term limits may continue existing State Plan coverage for six months from the last day of the legislator's final term of office as provided by 2-18-820, MCA (except that any optional life insurance benefits end at age 65 or when the legislator becomes Medicare eligible). During this time, the legislator will receive state contribution toward premium costs and will only need to self-pay the employee contribution. At the end of this six-month period, a legislator may continue core benefits (employee medical, dental, and core life insurance coverage) plus any existing optional vision and dependent medical and dental benefits, until the legislator becomes Medicare eligible. When coverage under this provision ends, legislators who meet the terms of E.8, provision 1, for a legislators leaving office may continue coverage under that provision.

F. CONVERSION RIGHTS

F.1 MEDICAL INSURANCE

An enrolled employee or dependent who loses eligibility for State Plan coverage and who does not elect to continue medical coverage under provisions of Section E, or who has exhausted or is ineligible for continuation rights under Section E, is entitled to convert indemnity medical plan coverage to a medical conversion plan provided by the State Plan's claims administration company. Requests must be submitted to the State Plan's claims administration company within 31 days of termination of State Plan coverage and premiums paid directly to the company. If you are on a managed care plan, check the Managed Care Plan Supplement for that plan to determine if you have a conversion option.

F.2 LIFE AND AD&D INSURANCE

An individual enrolled in life insurance under the State Plan, who loses eligibility for State Plan coverage, is entitled to convert to a life insurance plan provided by the State Plan's life insurance company. The conversion plan is a higher-cost plan, does not provide waiver of premium, and does not provide accidental death and dismemberment insurance. Requests must be submitted to the State Plan's life insurance company within 31 days of termination of State Plan coverage, and premiums must be paid directly to the company.

F.3 LONG-TERM CARE INSURANCE

An individual enrolled in the state group Long-Term Care Insurance Plan who loses eligibility for State Plan coverage, is entitled to convert to an individual policy at the same premium rate. Although rates will not increase due to conversion or age, they can be increased by the long-term care insurance company on a class basis according to underwriting risk studies. Conversion requests must be submitted to the long-term care insurance company within 31 days of termination of State Plan coverage and premiums paid directly to the company.

Additional information, forms, and assistance with requests are available from your agency payroll or personnel office and the EBB.

CHAPTER 2
HOW TO OBTAIN BENEFITS

Payment of benefits provided by the State Plan will be made on the basis of your submission of required information.

G. INDEMNITY MEDICAL & DENTAL PLAN BENEFITS

If your medical plan is a managed care plan, see that plan's Managed Care Plan Supplement alternative (Section G) for information on obtaining medical benefits. Use this Section G for dental benefits only.

G.1 Steps to Take in Advance of Receiving Services

(See G.6 for organ transplant services.)

1. Make sure you have a current identification card from the State Plan's claims administration company for use in obtaining dental benefits, and if on an indemnity medical plan, for use in obtaining medical benefits. Make sure it contains an identification number, correct name(s), dependent information, and correct date(s) of birth. If you need services before you receive your card or have lost it, ask your provider to verify your coverage by calling the claims administration company or the Employee Benefits Bureau (EBB). Replacement cards can also be ordered by calling the claims administration company.
2. In advance of receiving non-emergency services, know and optimize your benefits:
    a. Obtain pre-certification of inpatient hospital stays (all non-emergency inpatient hospital stays should be certified prior to admission to make sure they meet medical necessity requirements for inpatient benefits as described in G.4).
    b. Determine if you need prior authorization (described in G.5) for specific proposed medical or dental procedures, equipment, or supplies. (Some services require prior authorization in advance of services for benefits). Others should be prior-authorized if they are new or outside standard medical or dental practice (and may be excluded as experimental) or if they are only covered under some circumstances. See G.5 for a listing of services that must or should be prior-authorized (also specified for each service in Chapter 3) and see the current Annual Benefits Summary for updates.
    c. Determine if there are frequency, duration, or dollar limits on services you plan to receive. (See Chapter 3 and the current Annual Benefits Summary).
    d. Determine if there is a participating provider you can use who will accept allowable charges and not bill you for amounts over allowances. (For the most current participating provider listing, go to the web site of the State Plan's claims administration company shown on your identification card, or to the EBB web site and click on the link to the State Plan's claims administration company).
    e. Determine if there is a preferred provider you can use to obtain even better benefits. (See the current Annual Benefits Summary or the EBB web site for any preferred providers.)
    f. Obtain a pre-determination of what your out-of-pocket costs will be, if you are considering using a provider who is not a participating or preferred provider and will be responsible for any charges over allowed charges (see G. 3).
    g. Call the State Plan's managed care company for assistance in optimizing your benefits if you are diagnosed with a serious illness or suffer major injury (see L.39).

G.2 Steps to Take to Receive Payment

(See G.6 for organ transplant benefits.)

1. Present your current identification card to your physician, dentist, hospital, or other health care provider when you and covered dependents receive

services. Most providers will submit a claim to your State Plan's claims administration company for you.

2. Make sure your provider has your current identification number and address. If you change your address, be sure to notify the agency payroll staff and the claims administration company.

3. If your provider will not submit a claim to the State Plan's claims administration company, complete a standard claim form, which should be available from the provider. Have the provider complete his/her portion, and send the completed form, and all itemized bills to the State Plan's claims administration company at the address on your identification card.

4. Payment will automatically be sent directly to participating providers who have agreed to accept allowable fees. You will receive payment directly for services of non-participating providers unless they are preferred providers with special payment arrangements. For both participating and preferred providers, you will be responsible for deductible, coinsurance, and charges for non-covered services only, not for amounts above allowable charges.

5. Respond to requests for information on accidents, other insurance coverage or any other information requests from the State Plan's claims administration company. Your claim will not be paid until required information is received.

OUT-OF-STATE SERVICES

If you are receiving services out-of-state, check with the State Plan's claims administration company to identify participating providers or other providers who offer favorable fees and procedures for obtaining benefits.

As of the publication date of this Summary Plan Document, the State Plan's claims administration company is Blue Cross and Blue Shield of Montana, which provides the BlueCard Program. This program allows you to take advantage of other Blue Cross plans' provider arrangements. Claim information is sent from the Blue Cross and Blue Shield plan area where services are received (called the host plan) to the Blue Cross and Blue Shield plan area where the member is enrolled (called the home plan — Blue Cross and Blue Shield of Montana).

The host plan will electronically submit claims data to Blue Cross and Blue Shield of Montana for processing. Blue Cross and Blue Shield of Montana will determine what level of services are payable according to the State Plan, and send the information back to the host plan. The host plan will pay the provider, and for a small access fee, apply any provider-negotiated discounts and agreements to your claim.

If the Blue Cross and Blue Shield plan agreements with providers include hold-harmless provisions, providers cannot bill above the Blue Cross and Blue Shield allowable amount, and you will not be responsible for balances above the allowable amount. For a list of participating providers, contact Blue Cross and Blue Shield of Montana or log on to www.Bluecares.com.

Claims for services received from nonparticipating providers, claims for dental services, and claims for medical equipment may not be submitted by the provider. In these situations, the member must submit these directly to Blue Cross and Blue Shield of Montana. Reimbursement will be made directly to the member, and it is the member's responsibility to pay the provider.

OUT-OF-COUNTRY SERVICES

If receiving services out-of-country, check with the State Plan's claims administration company to identify any participating providers or other providers who offer favorable rates and for procedures for obtaining benefits. You may wish to check with the State Plan's claims administration company regarding requirements for documentation format to ensure proper claims processing.

As of the publication date of this Summary Plan Document, the State Plan's claims administration company is Blue Cross and Blue Shield of Montana, which provides BlueCard Worldwide Assistance. To receive this assistance when planning a trip abroad, call BlueCard Access at 1-800-810-2583 for available providers in your area of destination. General BlueCard information is also available at www.bcbs.com/healthtravel.

If you require services while traveling or working abroad, call the BlueCard Access line at 1-800-810-2583. A medical assistance coordinator, in conjunc-

tion with a nurse, will facilitate hospitalization or make an appointment with a physician. You must present your Blue Cross and Blue Shield plan identification card to the provider, who will verify your eligibility by calling the BlueCard Worldwide Service Center. For a medical emergency, go directly to the nearest hospital.

Inpatient participating hospital claims are filed by the provider, and you are not required to pay up front. You must only pay your deductible, copayment, coinsurance, and non-covered service charges. Outpatient hospital, inpatient non-participating hospital, or professional care claims are filed by you, the member. You pay the provider up front, and complete and send an international claim form to the BlueCard Worldwide Service Center.

CLAIMS FILING DEADLINE

Claims must be filed within one year from the date expenses were first incurred to receive benefits unless you show that it was not reasonably possible to file a claim within this time limit.

MEMBER SELF-AUDIT AWARD

Check bills from your medical providers to make sure you have not been double-billed for services or billed for services you haven't received, and receive an award of 50 percent of identified overcharges up to $1,000.

Plan members who identify over-charge errors in medical bills which:

a. have not already been detected by the State Plan's claims administration company or reported by the provider;
b. involve charges which are allowable and covered by the State Employee Benefit Plan; and
c. amount to $50 or more in over charges

may be eligible to receive a self-audit award of one-half of the savings obtained from billing adjustments, up to a maximum of $1,000.

To receive this self-audit award, the member must:

a. notify the claims administration company of the error before it is detected by the claims administration company or by the health care provider;
b. contact the provider to verify the error and determine or work out a correct billing; and
c. have copies of the corrected billing sent to the claims administration company for verification, claims adjustment, and calculation of the self-audit award.

EXPLANATION OF BENEFITS

Check the Explanation of Benefits (EOBs) from the State Plan's claims administration company to determine if you have received the benefits described in this document and what you owe the provider (the amount you owe in deductible, copayment, coinsurance, charges for uncovered services, and in the case of providers who are not participating or preferred providers, charges in excess of allowable charges).

CLAIMS ASSISTANCE

If you need assistance with filing a claim or an explanation of how a claim was paid, call your State Plan's claims administration company at the customer service number on your identification card.

G.3 PRE-DETERMINATION

If you are considering using a provider who is not a participating or preferred provider, you may wish to know in advance of receiving non-emergency medical or dental services what your out-of-pocket costs will be. This includes charges in excess of allowable fees, plus any deductible, copayment, or coinsurance obligation. You may determine this by calling the State Plan's claims administration company at the number on your identification card, or by sending a written request for a pre-determination. Your pre-determination request must include specific procedure codes and charges, which you will need to obtain from your health care provider. The final services rendered and coding for those services may differ and would not necessarily be the same as the pre-determination amount.

You will receive a determination of the allowable fee for each submitted procedure, which is a benefit of the State Plan. Please note that the allowable fee is not necessarily the same as the plan reimbursement, which is reduced by any deductible, copayment, and coinsurance you are required to pay and may be affected by waiting periods, coordination of benefits, and other State Plan provisions. The claims administration company can only advise you of your deductible and/or copayment or coinsurance obligation at the present time, which may not be the same as when claims for services are processed. If you obtain a pre-determination by phone, you may want to record the date and time. That will allow the State Plan's claims administration com-

pany to access their recording of your phone conversation at a later date, if documentation is needed.

G.4 Certification of Hospital Stays

All hospital inpatient days must be certified as medically necessary by the State Plan's case management company to be eligible for standard benefits. See L.3 for benefit reductions for non-certified days.

1. CALL-IN PRE-CERTIFICATION PROCEDURES

a. Non-Emergency Hospital* Admissions

Non-emergency hospital* admissions should be called in to the state's case management company for pre-certification (in advance of admission) to determine whether the admission meets medical necessity criteria for inpatient benefits before services are received. The hospital will typically make this call to assure payment, but since you are responsible for any charges that are not benefits of the State Plan, you may want to call for your own protection. Pre-certification is especially critical for *hospital admissions/stays for: organ transplant, treatment of mental illness, chemical dependency, and rehabilitation or recovery, as indicated in Chapter 3.

You may also want to record the date and time of the call so that the State Plan's case management company can access their recording of your phone conversation at a later date, if documentation is needed. Calling also allows you to take advantage of assistance by the case management company in obtaining appropriate care that maximizes your benefits and minimizes your out-of-pocket costs as described in L.29.

b. Emergency Hospital* Admissions

Emergency hospital* admissions should be called in to the State Plan's case management company for certification within 24 hours of the admission, or the first working day after the admission if it occurs over a weekend or a holiday, to determine whether continued stay meets medical necessity criteria for benefits before additional services are received. As for a non-emergency admission, the hospital will typically make this call to assure payment, but you or a representative may want to call to determine if continued inpatient services will be covered, and record the date and time of the call for later documentation as described above. Calling also allows you to take advantage of assistance by the case management company in arranging follow-up care that maximizes your benefits and minimizes your out-of-pocket costs.

*The term hospital, for purposes of certification, includes any facility which provides inpatient medical, psychiatric, or chemical dependency services, not just facilities licensed as hospitals.

c. How to Call and Who May Call

You, a family member, a friend, the hospital, or provider may call. The telephone number is listed on the back of your identification card. As indicated above, you may want to record the date and time of the call so that the recording can be retrieved at a later date if needed for documentation.

d. When the Call is Made

When the call is made, a registered nurse will request information such as your name, phone number, identification card number, diagnosis, date of admission to the hospital, name and phone number of your physician, and other information needed to certify your hospital stay as medically necessary. If information is needed that you, or a representative calling for you, cannot provide, the nurse will call your physician or the hospital.

If there is any question about whether your case meets medical necessity criteria, the nurse will refer your case to the physician advisor employed by the case management company. That physician will consult with your physician, and if need be, will consult with specialist physicians.

The medical necessity of your admission will then be certified for a specified length of stay, and you will receive written notification of the days certified. At the end of any certified days, the case management company nurse will contact the hospital to confirm your discharge. If you are not being discharged, the nurse will contact the hospital utilization review staff and your physician for additional information, and certify any additional days which meet medical necessity criteria.

Any time hospital days are denied certification, the case management company nurse will notify you

or your representative within 24 hours of the decision. See J.3 for appeal rights. Assistance with arranging continuing outpatient care is available upon request as described in L.39.

2. IF NO ONE CALLS FOR CERTIFICATION

The hospital stay will be reviewed after the fact, when claims are submitted, and any eligible inpatient days certified at that time. However, with a post-hospitalization review, you always run the risk that all, or a portion of the stay, will be found ineligible for standard benefits when it is too late to consider alternatives. The call-in certification process was established to give you advance notice.

G.5 Prior Authorization

1. REQUIRED PRIOR AUTHORIZATION

A few medical services, equipment, and supplies require prior authorization in order to receive benefits. At the time of this document's publication, some of these are:

a. durable medical equipment and prosthesis expenses over $500 (L.20).

b. infertility treatment (L.35).

c. obesity treatment (L.37).

d. intensive out-patient rehabilitation for services that exceed the standard dollar benefit described in your current Annual Benefits Summary (L.31).

e. surgical treatment of Temporomandibular Joint (TMJ) Disfunction (L.40, provision 20).

To check if procedure or service requires prior authorization, call the claims administration company. Some prescription drugs require prior authorization. Since these change more frequently than other medical services, please see the claims administration company web site for a current listing, or call the customer service number on your prescription drug identification card concerning a particular prescription.

Dental services may also require prior authorization in order to receive benefits. At the time of this document's publication these are:

a. dental implants (N.6, provisions 5 and 6).

There are no benefits for services, equipment, and supplies requiring prior authorization unless they are approved in advance of receipt. See your current Annual Benefits Summary or the EBB web site (www.discoveringmontana.com/doa/spd/css/benefits/healthbenefits.asp) for updates.

2. RECOMMENDED PRIOR AUTHORIZATION

You should obtain prior authorization for any proposed procedures, equipment, or supplies that are not clearly a benefit of the State's indemnity medical plan, are only a benefit under some circumstances, or that may not meet medical necessity criteria because they are new, extraordinary, potentially experimental, or possibly contrary to accepted medical policy.

You are strongly encouraged to prior-authorize the following medical services, equipment, and supplies:

a. partial hospitalization for treatment of mental illness (L.23).

b. home health services (L.28).

c. skilled nursing services (L.30).

Please check with the claims administration company for recommended prior authorizations.

3. PROCEDURE

To obtain a prior authorization, you and/or your health care provider may call the State Plan's claims administration company at the customer service number on your identification card, or send a written request. Your prior authorization request must include information by your health care provider explaining the proposed services, equipment or supplies, the functional aspects of treatment, the projected outcome, treatment plan, and any other supporting documentation, study models, photographs, x-rays, etc. Allow ten (10) days for a prior authorization response.

G.6 Organ or Tissue Transplant Benefits

To receive organ transplant benefits (bone marrow, heart, heart/lung, liver, lung and pancreas — described in L.26), take the following steps:

1. Pre-certify the planned transplant by calling the customer service number listed on your identification card. Ask for the names of participating provider

hospitals in the national transplant network provided by the State Plan's claims administration company.

2. Use one of the hospitals in this network, if possible, to make sure charges are allowable charges under your indemnity medical plan.

3. The hospital or provider may call the customer service number on your identification card to verify eligibility.

4. File claims like claims for other medical services as described in Section G.2.

H. PRESCRIPTION DRUG BENEFITS

H.1 Steps to Take in Advance of Obtaining Prescription Drug Benefits

1. Make sure you have a current State Plan prescription drug identification card from the State Plan's prescription benefits management company and that it contains an identification number, correct name(s) and dependent information, and correct date(s) of birth. If you need services before you receive your card or have lost it, ask your provider to verify your coverage by calling the prescription benefits management company or the EBB.

2. In advance of obtaining prescription drugs, know and optimize your benefits:

   a. Talk with your physician and pharmacist about whether the medication you need comes in a generic prescription. Generics have the same chemical compound as the brand name version and are available after the original brand-name manufacturer's patent has expired. They are your lowest-cost option. (See the current Annual Benefits Summary for your copayment and/or coinsurance on a generic prescription.)

   b. If a generic prescription is not available, talk with your physician about prescribing a brand-name prescription on the prescription drug management company's formulary. The formulary is a listing of preferred brand name prescriptions in each therapeutic class. Listed prescriptions are preferred because of their effectiveness and favorable cost, including favorable manufacturer rebates. Rebates, negotiated by the State Plan's prescription benefits management company, offset the State Plan's and members' costs. Formulary brand-name prescriptions are your second lowest-cost option. (See the current Annual Benefits Summary for your copayment and/or coinsurance on formulary prescriptions.)

   Go to the web site of the State Plan's prescription drug benefits management company (on your prescription drug identification card) for a current formulary listing. The formulary listing changes from time to time and the web site listing is kept current. You may also call the customer service number on your identification card. Hard copies of formulary updates are also sent to members when there are significant changes.

   c. Determining if the prescription drug you need is a covered benefit of your State Plan requires prior authorization or requires contingent step therapy. You can find this information on the prescription drug vendor web site at www.ehs.com or by calling the customer service number on your prescription drug identification number. Prior authorization is primarily required for prescriptions that can be used for purposes that are not covered by the State Plan. Contingent step therapy (trying lower-cost options before moving to a higher-cost option) may be required for coverage of some higher-cost prescriptions that have good lower-cost alternatives.

H.2 Prescriptions From a Pharmacy

1. To receive prescription drug benefits from a participating pharmacy, take your prescription drug identification card along with your prescription to any participating pharmacy. The pharmacist will process your prescription electronically for up to a 30-day supply and collect only your portion of the cost (deductible, copayment, and/or coinsurance). You will not need to file a claim. To identify participating pharmacies, call the prescription benefits management company at the customer service number on your prescription drug identification card or visit the web site shown on your prescription drug identification card.

2. To receive prescription drug benefits from a non-participating pharmacy, you pay the entire cost of the prescription and file a claim with the prescription benefits management company for reimbursement of plan allowances. Claim forms are available from the EBB or prescription drug company. Allowances may not cover the entire cost less your deductible/copayment.

H.3 Mail Order Prescriptions for Maintenance Drugs

For maintenance drugs you don't need immediately (make sure to have a two to three week supply on hand), send your prescription(s) for up to a 90-day supply, along with your copayment, to the mail service provided by the State Plan's prescription benefits management company. The amount of the copayment you should send can be obtained from the current Annual Benefits Summary. If you are uncertain, call the customer service number on your prescription drug identification card for assistance.

H.4 If a Dependent is Covered by Another Primary Prescription Drug Plan

If another prescription drug plan is responsible for primary payment of a dependent's prescription drug expenses (described in Chapter 7), that plan must pay first.

To receive a secondary payment from the State Plan, submit a receipt showing your out-of-pocket costs (that the other plan did not pay) and the prescription to the State Plan's prescription drug management company at the address indicated on your prescription drug card. See K.2, provision 4, for information on secondary benefits.

I. MISCELLANEOUS BENEFITS

Optional Vision Insurance Plan, Employee Assistance Program, Flexible Spending Account, Life Insurance Plan, Accidental Death and Dismemberment Insurance Plan, and Long-Term Care Insurance Plan Benefits

I.1 Optional Vision Insurance Benefits

To receive vision exam and eye ware benefits you must have enrolled in a separate optional vision insurance plan.

To assure that you or another enrolled family member pay no more than the copayment specified in the current Annual Benefits Summary for an eye exam and fully-covered lenses, schedule your eye exam and/or eye ware purchase according to the schedule of benefits (also in the Annual Benefits Summary) and use a participating provider of the State Plan's vision insurance company. Participating providers have agreed to accept plan payments plus your copayment as full compensation for routine exams and fully covered lenses. Some other providers will also accept plan payments plus your copayment as full compensation.

To obtain a list of participating providers, call the customer service number, or visit the web site of the State Plan's vision insurance company (provided in the current Annual Benefits Summary).

1. To receive benefits from a participating provider, make an appointment, mention that you (or an enrolled family member) are enrolled members of the State Plan's vision insurance company, and provide any information the provider needs to verify your eligibility for benefits with the vision insurance company. The provider will collect any copayments and uncovered costs from you and obtain payment for covered costs directly from the vision insurance company.
2. To receive benefits from a non-participating provider, you pay the entire cost of the eye exam and/or eye ware and send an itemized receipt to the State Plan's vision insurance company within six months from the date of service. Included with the receipt should be the subscriber's name, phone number, address, member I.D., the name of the group (State of Montana), the patient's name, date of birth, phone number, address, and the patient's relationship to the subscriber. The Vision Insurance Plan will reimburse you for costs (less your copayment) up to allowable fees. For current allowable fees, see the current Annual Benefits Summary, the EBB web site or the web site of the State Plan's vision insurance company (provided in the current Annual Benefits Summary).

I.2 Employee Assistance Program Benefits

To receive Employee Assistance Program (EAP) benefits described in M.2, make an appointment with an available EAP counselor near you. All State Plan members — regardless of their selected medical plan — are eligible for EAP benefits, and there is no separate premium for this coverage. You may obtain information on EAP from the EBB web site, or by calling or visiting the web site of the State Plan's Employee Assistance Program administrator (current phone numbers and web addresses provided in the current Annual Benefits Summary).

I.3 Flexible Spending Account (FSA) Benefits

In any benefit year, you may receive Flexible Spending Account benefits, only if :

1. You have enrolled in an FSA for that benefit year.
2. You incur qualified expenses during the year (while still enrolled).
3. You file a timely claim for reimbursement or payment.

Any money in an FSA not used for qualified expenses incurred during the benefit year is forfeited at the end of the benefit year. Expenses are incurred when the services are received or a product ordered. This may or may not be the same time that you are billed, so it is important to work with the FSA program administrator in setting up an FSA and submitting claims for services that span more than one benefit year, such as orthodontia services. (See Chapter 1 for information on

enrolling in FSAs, restrictions on making changes to FSAs, and continuing or reinstating an FSA after you terminate employment or take a leave of absence.)

To receive reimbursement from a Medical FSA for an incurred eligible medical expense which is not covered by health insurance, submit a claim form and expense receipt to the State Plan's Flexible Spending Account program administrator (specified in the current Annual Benefits Summary). For an incurred eligible medical expense that is covered by health insurance, submit a claim form and a copy of the Explanation of Benefits from the health insurance plan showing the portion of the expense you must pay. The FSA program administrator processes routine claims and sends reimbursement due on the next business day following receipt. IRS regulations require Medical FSAs to reimburse a claim up to the elected annual amount minus any reimbursements already received, regardless of the account balance at the time the claim is submitted. See Chapter 6 for eligible medical expenses.

To receive reimbursement from a Dependent Care FSA for an incurred eligible day care expense, submit a claim form and expense receipt to the FSA program administrator. Only amounts up to the current balance of a Dependent Care FSA are reimbursable. Due to the state's payroll deduction schedule, a full month of FSA contribution is typically not available until the middle of the following month. You should consequently plan on paying the first month of day care expenses from other sources, unless the day care provider is willing to wait for payment.

Claim forms are available on the web site of the State Plan's FSA program administrator. See the address in the current Annual Benefits Summary or on the EBB web site.

I.4 Life and Accidental Death and Dismemberment Benefits

You or your beneficiary (in the case of your death) may file a benefits claim for any life insurance or accidental death and dismemberment insurance, in which you or dependents are enrolled, by contacting the EBB. A certified death certificate or attending physician's statement to verify the loss will be required.

I.5 Long-Term Care Insurance Benefits

To file a long-term care insurance claim, contact the State Plan's long-term care insurance company with which you enrolled at the number in your long-term care insurance enrollment kit. You may also obtain the number from the EBB web site at (www.discoveringmontana.com/doa/spd/css/benefits/healthbenefits.asp) or by calling the EBB at 444-7462 in Helena, or 1-800-287-8266 outside of Helena.

J. REVIEW OF CLAIMS DENIED IN WHOLE OR IN PART

J.1 Level 1 Review of Claims

If you believe that you have been inappropriately denied benefits described in this Summary Plan Document or a Managed Care Plan Supplement to the document, you are encouraged to call the plan's customer service number for an explanation. If unsatisfied with the response, call or send a written Level 1 Review request for review as described in this provision. If you are not satisfied with the response to the Level 1 Review, you may request a formal Level 2 Review as described in J.2. A Level l Review must be conducted prior to a request for a Level 2 Review. We expect that most problems can be solved through the less formal Level 1 Review process.

1. MEDICAL AND DENTAL CLAIMS

When a claim for medical or dental benefits is processed, you will receive an Explanation of Benefits (EOB) from the company that processed the claim. This provides an explanation of any denials or reduction in benefits. You may request further explanation of the reasons by calling the number on the EOB or the customer service number on your identification card for the plan. If not satisfied with the explanation, you may call or send a written request for a Level 1 Review within 90 days of receipt of the EOB.

2. PRESCRIPTION DRUG CLAIMS

If you believe that you have been inappropriately denied prescription drug benefits described in this Summary Plan Document, you are encouraged to call the customer service number on your prescription drug identification card for an explanation. If you are unsatisfied with the response, you may call or submit a written informal, or Level 1, appeal to the State Plan's prescription benefits management company within 60 days of the denial or benefit reduction you are appealing.

3. LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, AND LONG-TERM CARE INSURANCE CLAIMS

If you receive a notice that a life or AD&D insurance claim has been denied, you may call the State Plan's life and accidental death and dismemberment company for an explanation, and send a written request for a review, along with supporting documentation within 60 days of receipt of the denial.

If you receive a notice that a long-term care insurance claim has been denied, you may call the State Plan's long-term care insurance company, with which you enrolled, for an explanation, and send a written request for a review along with supporting documentation within 60 days of receipt of the denial.

4. VISION INSURANCE CLAIMS

If you are denied vision insurance benefits, you or your vision provider may call the state's vision insurance plan company for an explanation. If you are unsatisfied with the response, you may send a written request for a review to the vision insurance plan company within 60 days.

J.2 Level 2 Review of Claims

1. MEDICAL AND DENTAL CLAIMS

If you are not satisfied with the response to the Level 1 Review, you may initiate a formal petition for Level 2 Review by the EBB. A petition of review must be in writing, stating the reason or reasons you or your health care provider are disputing the denial, and including documentation of the informal review process. This petition must be filed with the EBB within 90 days of the date of the notice of the informal-review denial. The EBB will review the arguments presented and may forward the petition to the claims administrator who denied the claim for a formal reconsideration, if circumstances warrant.

The petition may be amended or supplemented and opportunity may be granted to receive and hear any evidence or argument that cannot be presented in correspondence. Such information will be received and heard in Helena, Montana, unless another city is considered more appropriate by the EBB.

A written decision will be made by the EBB within 30 days of the date the petition is filed or within 120 days if special circumstances require an extension.

2. PRESCRIPTION DRUG CLAIMS

If you are not satisfied with the response to the Level 1 Review of a prescription drug claim, you may submit a second appeal to the State Plan's prescription benefits management company within 60 days of receipt of the response. The claim will be reviewed by a special review committee of representatives of the prescription benefits management company and a representative of the EBB. A written decision explaining the basis of the decision will be issued within 30 days, or within 60 days if special circumstances require an extension.

3. VISION INSURANCE, LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, AND LONG-TERM CARE INSURANCE CLAIMS

Since vision, life, accidental death and dismemberment, and long-term care insurance plans are not self-insured by your employer, final claims decision are made by the relevant insurance company. You may request information from the EBB about the policy and contract terms by submitting a copy of the denial and other documentation to the EBB within 60 days of receipt of the decision.

4. MEMBER RESPONSIBILITY

Failure to file a petition for Level 1 Review within Level 1 time frames (described in J.1) or to file a petition for a Level 2 Review within Level 2 time frames (described in J.2), or the failure by you or your representative to appear at a scheduled review session shall constitute a waiver of the right to file or continue a Level 2 petition. However, the EBB may waive the time limit for good cause.

J.3 APPEAL OF PRIOR AUTHORIZATION AND CERTIFICATION ACTIONS

If you or your physician disagree with a certification denial of inpatient services under an indemnity medical plan (described in G.4 of this chapter) or a prior authorization decision (described in G.5 of this chapter), you may appeal the decision.

You have 60 days from the date you are notified of the decision to submit an appeal request. You can do this by calling the customer service number on your identification card or directly calling the State's managed care company. The State's managed care company will send you the necessary forms to initiate the process and provide nurse assistance with the appeal. The decision on the review will be made in writing within 60 days after receipt of all relevant medical records

If you are on a managed care plan and are informed that requested services will be denied as not medically necessary or not a benefit of the plan, you may initiate a Level 1 and Level 2 Review (described in J.1 and J.2) prior to receipt of services.

CHAPTER 3
MEDICAL BENEFITS

K. PRESCRIPTION DRUG PLAN BENEFITS & EXCLUSIONS

K.1 Separate Prescription Drug Plan

Prescription drugs are covered by a separate Prescription Drug Plan, which is administered by the State Plan's prescription benefits management company, for all State Plan members — regardless of their selected medical plan. There is no separate premium. Any deductible, copayments, or coinsurance you are required to make are separate from medical plan deductible or copayments and coinsurances, and are accumulated to a separate annual out-of-pocket maximum.

K.2 Covered Prescription Drug Expenses and Plan Payment

1. COVERED PRESCRIPTION DRUG EXPENSES

Expenses, within allowable fees of the State Plan's prescription benefits management company, for plan-allowed quantities of federal legend drugs and compound medications that contain at least one federal legend drug in a therapeutic amount are covered, provided the drug meets the following requirements:

a. is prescribed by a professional provider licensed to prescribe legend drugs for approved use in the treatment of an injury or illness.

b. is dispensed by a licensed pharmacist or licensed physician or surgeon.

c. is listed in the American Medical Association Drug Evaluation, Physician's Desk Reference, or Drug Facts and Comparisons.

d. is not a specific exclusion of the State Plan's Prescription Drug Plan as described in K.3, as updated by the Employee Benefits Bureau (EBB) web site.

e. meets other requirements of the State Plan's Prescription Drug Plan including prior authorization and contingency step therapy requirements described below and on the State Employee Benefits Plan web site update.

f. provided any other requirements of this Summary Plan Document are met, including the one-year waiting period for new enrollees without creditable coverage as described in C.5.

Other Covered Expenses

The Prescription Drug Plan also covers expenses, within allowable fees, of the following drugs and supplies (provided requirements described in K.2, provisions 1.e. and 1.f., are met):

a. diabetic drugs and supplies, including injectable insulin, blood glucose monitoring machines, diagnostic testing agents, hypoglycemia rescue agents (glucose tablets), lancets, Lancet auto-injectors insulin syringes, and insulin auto-injectors and their needles;

b. syringes and needles for other medical conditions;

c. prenatal vitamins at zero copayment when prior-authorized for expectant mothers participating in the Maternity Case Management Program (see L.39, provision 3) — call the State Plan's managed care company for more information; and

d. contraceptives, oral and injectable, except emergency "morning after" contraceptives such as Preven and Plan B.

2. COVERED PRESCRIPTION DRUG EXPENSES YOU PAY

You pay a designated deductible, coinsurance (percentage), copayment (dollar amount), or combination of the above for each prescription for yourself or an en-

rolled family member until you reach, or the family member reaches, your individual out-of-pocket maximum for the benefit year, or until your family reaches the family out-of-pocket maximum for the benefit year. The State Plan pays remaining covered prescription drug expenses, defined above.

See the current Annual Benefits Summary or the EBB web site for the following:

a. the quantity of covered prescription drugs you may receive from a retail pharmacy and from the prescription drug management company's mail services.

b. the deductible, coinsurance, copayment, or combination you pay for a prescription drug and the annual out-of-pocket maximum per member and per family. Deductible, copayment, and/or coinsurance amounts vary depending on:
   1) whether the prescription is received from a pharmacy or the mail services; and
   2) whether the prescription is:
      a) a generic prescription — the lowest cost option;
      b) a brand name prescription on the prescription benefits management company's formulary — the next lowest cost option; or
      c) a brand name prescription, which is not on the formulary — the highest cost option.

A current listing of prescriptions on the prescription benefits management company's formulary can be obtained by going to the EBB web site, or the prescription benefits management company's web site, shown on your identification card. The prescription benefits management company also sends members hard copy listings when there are significant changes.

3. PARTICIPATING PHARMACIES

If you obtain prescriptions from the prescription benefits management company's mail services or one of its many participating retail pharmacies, which accept allowable fees, you will pay your deductible, copayment, and/or coinsurance only. If you use a non-participating pharmacy, you pay the entire cost of the prescription and submit a claim for reimbursement, but you will only be reimbursed up to the allowable fee less your deductible, copayment, and/or coinsurance. Go to the EBB web site for a link to the applicable listing of participating pharmacies and information on mail order services. You may also call the customer service number on your prescription drug identification card to find a participating pharmacy near you, or ask a pharmacy if they are a participating pharmacy with the State Plan's prescription benefits management company.

4. WHEN A PLAN MEMBER HAS OTHER PRIMARY PRESCRIPTION DRUG INSURANCE COVERAGE

When another medical or prescription drug insurance plan is responsible for primary payment of prescription drug costs, the State Plan's Prescription Drug Plan coordinates its benefits with the benefits provided by the primary plan. As the secondary plan, the State Plan will reimburse you for any out-of-pocket costs (costs not paid by the other plan) less the deductible and/or copay that is due under the State Plan. To receive a secondary payment you must submit a receipt showing your out-of-pocket costs and the prescription to the State Plan's prescription drug management company at the address (attention: COB processing) indicated on your prescription drug identification card.

K.3 EXCLUDED PRESCRIPTION DRUG EXPENSES

Expenses for the following drugs, as updated on the prescription drug company web site, are exclusions of the Prescription Drug Plan:

1. Drugs or supplies prescribed for cosmetic purposes, such as Rogaine, Renova, or Propecia for normal hair loss, or Differin or Retin-A for individuals over age 25 unless prior-authorized for a medical condition.
2. Smoking cessation agents such as Zyban or patches.
3. Growth hormones unless prior-authorized.
4. Anorexiants (such as Meridia and Xenical) unless prior-authorized.
5. Vitamins (except prenatal vitamins obtained through the State Plan's managed care company for participating in the Maternity Case Management Program).
6. Fluoride supplements.
7. Nutritional or naturopathic supplements (except medical foods to treat inborn errors of metabo-

lism as defined in 33-22-131 MCA), unless a legend drug prior-authorized for a medical condition.

8. Implantable insulin pumps and supplies (covered under the medical plan).
9. Therapeutic devices or appliances, such as pulmoaid pumps or minimed pumps (covered under the medical plan).
10. Created combinations of raw bulk chemical ingredients (such as progesterone, testosterone, or estrogen powders) or combinations of federal legend drugs in non-FDA-approved dosage form (such as capsules or suppositories made from DHEA, progesterone, testosterone, or estrogen powders) unless authorized by the EBB.
11. Immunization agents, biological serum, or vaccines.
12. Anabolic steroids, unless prior-authorized for a medical condition.
13. Neurominidase inhibitors such as Relenza Diskhaler or Tamiflu caps.
14. Impotence treatment drugs, such as Viagra.
15. "Morning after" or emergency contraception, such as Preven and Plan B.
16. Non-legend drugs, over-the-counter drugs, legend drugs for which an over-the-counter version is available, and state-restricted drugs unless specifically included above or on the EBB web site update, such as progesterone suppositories.
17. Experimental or investigational drugs or drugs prescribed for experimental (non-FDA-approved/unlabeled) indications or in dosages above recommended levels, unless such dosages are approved by the prescription benefits management company.
18. Charges for the administration of the injection of any prescription drug.
19. Drugs for a treatment excluded under general medical exclusions of Section M of this document, the current Annual Benefits Summary, or an applicable Managed Care Plan Supplement to this document.

K.4 Prescription Drug Benefits with Prior Authorization or Other Requirements

A number of prescription drugs require prior authorization by the State Plan's prescription benefits management company for coverage. See the prescription drug company web site for a current list of prescription drugs which require prior authorization, or call the customer service number on your prescription drug identification card to determine if a particular prescription drug requires prior authorization.

The following drugs may be covered if prior-authorized by the company which administers your medical plan:

1. Fertility drugs as part of a prior-authorized in-vitro fertilization benefit.
2. Weight-loss medication as part of a prior-authorized weight-loss program.

Some high-cost prescriptions with good lower-cost alternatives may require contingent step therapy (trial of a less costly drug first). Currently, anti-rheumatic drugs such as Celebrex and Vioxx require contingent step therapy. See the prescription drug company web site for updates, or call the customer service number on your prescription drug identification card.

Some drugs with special handling or distribution requirements are only available through a retail pharmacy, not the mail services. As of the publication date of this document, these are: Avonex, Betaseron, Ceredase, Cerezyme, Copaxone, and Rebif. See the EBB web site for updates.

L. INDEMNITY MEDICAL PLAN BENEFITS AND EXCLUSIONS

If your medical plan is a managed care plan, see that plan's Managed Care Plan Supplement for alternative Section L. The benefits below do not apply.

L.1 Covered Medical Expenses and Plan Payment

1. COVERED MEDICAL EXPENSES

Expenses covered by a state-sponsored indemnity medical plan are:

a. expenses within allowable charges (you are responsible for expenses over allowable charges unless you use a participating or preferred provider — see G.1 and G.2);
b. expenses within specified benefit limitations contained in this chapter and which meet other requirements of this Summary Plan Document; and
c. expenses for covered medical services.

Covered Medical Services

Covered medical services are services, procedures, and supplies:

a. listed in this section and not excluded in L.40;
b. determined to be medically necessary for the diagnosis or treatment of:
    1) injury;
    2) illness; or
    3) maternity, preventive, or managed care services specified in L.36 and L.39. (Expenses associated with inpatient hospital days only meet medical necessity criteria if they are certified as described in L.2.)
c. provided to a member by a covered provider; and
d. provided and coded in accordance with applicable medical policy, as defined in Chapter 9.

2. COVERED MEDICAL EXPENSES YOU PAY

Deductible

You pay your (and each enrolled dependent's) first covered medical expenses in a benefit year that are subject to deductible, until you have met the individual or family deductible requirement for your plan. See the current Annual Benefits Summary for the individual and family deductible amounts and the covered medical services that are subject to deductible for your medical plan.

Coinsurance

After you have met deductible requirements, you pay a coinsurance percentage on any of your (and each enrolled dependent's) covered medical expenses which require coinsurance, until you have met your individual or family out-of-pocket maximum for the benefit year. The plan then pays 100 percent of covered medical expenses for the remainder of the benefit year — with the exception of those that require a specified copayment described below. To determine the coinsurance percentage you pay, the covered medical services to which it applies, and the benefit year's out-of-pocket maximum for your plan, see the current Annual Benefits Summary.

Copayment

You pay a specified dollar copayment on your (and each enrolled dependent's) covered medical expenses that require a copayment. There is usually no out-of-pocket maximum on copayments. For required copayments for your medical plan, see the current Annual Benefits Summary.

3. PLAN PAYMENT MAXIMUMS

A state-sponsored indemnity medical plan pays allowable charges for any covered medical expenses that are not your responsibility as defined in L.1, provision 2, until it reaches the maximum lifetime benefit payable to any one person. For your plan's maximum lifetime benefit, see the current Annual Benefits Summary. Once this limit is reached, a minor benefit (currently $2,000 each benefit year) is restored to the maximum lifetime benefit for your medical plan only — not to your Prescription Drug Plan.

RELATED INFORMATION

Some medical services contain their own benefit maximums in the form of annual or lifetime dollar limits, or limits on the duration or frequency of services covered by the plan. These are contained in the descriptions of the specific covered medical expenses in this section and may be updated in the Annual Benefits Summary for the current benefit year.

If you have a major or chronic illness or serious injury, you are encouraged to use the managed care services described in L.39 to get the most out of these benefits and help control your costs.

L.2 Certification Requirement for Inpatient Hospital Coverage

Inpatient hospital stays (hospital confinement of 24 hours or more) are reviewed by the State Plan's medical case management company to determine if inpatient hospitalization is medically necessary (as defined in Chapter 9). Only charges for hospital days certified as medically necessary are eligible for standard inpatient benefits described in this section. Plan members can determine whether medical necessity criteria is met by calling the customer service number on their identification card in advance of a non-emergency hospital admission and within 24 hours (or the first working day) after an emergency hospital admission as described in G.4.

Weekend hospital days resulting from a weekend admission are typically only certified when the admission results from an injury or emergency illness, or is related to pregnancy.

Additional hospital days (beyond the number originally certified) will be reviewed by the medical case management company and certified if the member's condition meets medical necessity requirements for continued inpatient care.

Surgeries commonly performed safely in an outpatient setting are typically not certified for inpatient hospital services. If you would like additional information regarding what procedures are commonly performed on an outpatient basis call the customer service number on your identification card.

Assistance in finding appropriate outpatient treatment is available upon request when inpatient days are denied certification (see L.39).

L.3 Coverage of Medical Expenses for Certified and non-Certified Hospital Stays

1. Medical services received during a hospital stay certified as medically necessary, are covered as described in this chapter.

2. When all or part of the hospital stay fails to be certified as medically necessary, either through the call-in process (described in G.4) or after the fact when claims are processed, coverage is as follows:

   Only expenses that would have been incurred for outpatient treatment are covered for any hospital days that are not certified. Hospital room and board is not covered and other hospital expenses may not be eligible for coverage.

L.4 Inpatient Hospital Services

(Certification requirement applies. See L.3 for coverage of non-certified days.)

The following inpatient hospital services are covered for days that the member is confined to a licensed hospital, provided the inpatient days are certified as medically necessary for treatment of an injury or illness as required in G.4:

(To be eligible under this provision, the services must not be primarily for rehabilitation care, which is covered under L.31.)

1. Bed, board, and general nursing services in semiprivate (two or more beds) accommodations. The plan will allow the hospital's average semiprivate room charge as the allowance toward a private room.

2. Bed, board, and both general and concentrated nursing services provided by nurses who are hospital employees in intensive care and cardiac care units.

3. Miscellaneous hospital services and services provided by covered providers on the hospital's staff as described below:

   a. operating room, recovery room, and delivery room;

   b. surgical and anesthetic supplies;

c. splints, casts, and dressings;

d. drugs and medicines which:

   1) are approved for use in humans by the U.S. Food and Drug Administration;

   2) are listed in the American Medical Association Drug Evaluation, Physician's Desk Reference, or Drug Facts and Comparisons; and

   3) require a physician's written prescription.

e. oxygen and use of equipment for its administration;

f. intravenous injections, and setups for intravenous solutions including the solution, if included in L.4, provision 3.d., above;

g. physical therapy, if administered by or under the supervision of a registered physical therapist employed by the hospital; speech therapy; occupational therapy is only covered as an outpatient service (provision L.31);

h. chemotherapy, radiation therapy, and dialysis therapy;

i. respiratory therapy if administered by or under the supervision of a registered respiratory therapist employed by the hospital;

j. administration of blood (blood donor's fee is excluded);

k. laboratory services;

l. x-rays and other medically necessary diagnostic services; and

m. other medically necessary inpatient hospital services.

L.5 Outpatient Hospital Services

Hospital services and supplies described above in provision L.4 are covered if a member is treated at a licensed hospital, but not admitted for bed patient care, with the exception of physical and speech therapy (covered under L.31).

Charges for observation beds/rooms are covered when medically necessary and in accordance with medical policy for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day.

L.6 Emergency Room Services

(Certification requirement applies if admitted for inpatient care.)

Benefits for services and supplies rendered in the emergency room of a hospital are covered for emergency medical conditions defined in Chapter 9.

L.7 Licensed Ambulance Service

Licensed ground or air ambulance services are covered to the nearest hospital equipped to provide necessary treatment, when the service is for a life-endangering emergency medical condition or injury. Ambulance transport must be medically necessary, meaning that other forms of transportation would endanger the health of the member. Benefits will not be provided for transportation of the medical team when not accompanied by the patient, or for waiting time charges. Prior authorization (prior to treatment) is strongly recommend to assure coverage of any non-emergency air or ground ambulance transportation.

L.8 Surgical Services

(Certification requirement applies if performed inpatient. See L.3 for coverage of non-certified hospital days.)

Medically necessary surgical services are covered, including normal pre- and post-operative care, for the surgical treatment of injuries and illnesses including treatment of fractures, dislocations, vasectomies, and other surgical sterilization procedures rendered by a licensed surgeon/physician. Payment for these services is subject to the following conditions:

1. When two or more surgical procedures are performed, payment will be made for the allowable charge of the procedure with the highest allowance, plus one half of the allowable charge for the procedure with the lowest allowance. No additional payment will be made for incidental surgery. Incidental surgery is a procedure which is an integral part of, or incidental to, the primary surgical service and performed at the same operative session.

Surgery is not incidental if:

a. it involves a major body system different from the primary surgical services; or

b. it adds significant time or complexity to the operating session and patient care.

2. If an operation or procedure is performed in two or more steps, total payment will be limited to the allowable charge for the initial procedure.

3. If two or more surgeons perform operations or procedures together, other than as an assistant at surgery or anesthesiologist, the allowable charge will be divided among them. (This condition is subject to the conditions in L.8, provisions 1 and 2.)

4. Assistant-at-surgery charges for actively assisting the operating physician in the performance of covered surgery, will be paid as follows depending on whether the assistant-at-surgery is a physician or non-physician assistant:

   a. Assistant-at-surgery performed by a physician will be paid at 20 percent of the allowable charge for the surgical procedure, or the assistant's charge, whichever is less.

   b. Assistant-at-surgery performed by a non-physician assistant or surgical technician will be paid at 10 percent of the allowable charge for the surgical procedure, or the assistant's charge, whichever is less.

   c. Benefits are not available when an assistant-at-surgery is present only because the facility provider requires such services — for teaching purposes, for example.

   d. Benefits for an assistant-at-surgery will be paid only if the State Plan determines that such services were necessary.

   e. If two physicians are paid as primary surgeons or co-surgeons for their multiple surgeries, no allowance as an assistant-at-surgery will be made to either of the surgeons. Any charges for an additional assistant-at-surgery will be subject to review.

5. The charge for a surgical suite outside a hospital is included in the allowable fee for the surgery.

6. Reconstructive breast surgery following mastectomy (surgical removal of the breast) including:

   a. reconstructive breast surgery when a mastectomy resulted from breast cancer; and
   b. reconstructive breast surgery on the non-diseased breast to establish symmetry.

L.9 Freestanding Surgical Facilities (Surgicenters)

Medically necessary services of a surgicenter are covered, including recovery care beds, defined in Chapter 9, if the following criteria are met:

1. the center is licensed or certified by Medicare by the state in which it is located.

2. the surgical procedure performed is recognized as a procedure which can be safely and effectively performed in an outpatient setting.

L.10 Inpatient Provider Services – Excluding Surgical Services Covered Under L.8

(Certification requirement applies. See L.3 for coverage of non-certified days.)

In-hospital services by a covered provider are covered for days that a member is confined to a licensed hospital as a registered bed patient under the care of a licensed physician or surgeon, provided the inpatient days are certified as medically necessary according to G.4. See L.3 for coverage of charges for non-certified hospital days.

Benefits for medical care visits are limited to one visit per day per covered provider, unless the member's condition requires intensive medical care (a physician's constant attendance and treatment for a prolonged period of time).

L.11 Anesthesia Services

(Certification requirement applies to inpatient services. See L.3 for coverage of services for non-certified hospital days.)

Coverage includes anesthesia services rendered and billed by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist for medically necessary care of a condition covered under this document.

Benefits will not be provided for the following:

1. Hypnosis.
2. Local anesthesia (paid as part of a global procedure charge).
3. Anesthesia consultations before surgery (paid as part of the anesthesia charge).
4. Anesthesia for dental services or extraction of teeth (except those covered by L.13).

L.12 Office Visit Services

Covered office visit services are health care services provided by a physician, mid-level practitioner in a physician's office or clinic, or other covered providers in the office/clinic staff under physician direction. This includes but is not limited to diagnostic services, treatment services, laboratory services, x-ray and radiation services, and referral services.

Benefits will not be provided for the following:

1. Routine physical examinations (including those required for school, athletics or employment).
2. Screening examinations, except those listed in L.36.
3. Pre- or post-surgical visits considered to be inclusive services.
4. Conditions for which maternity benefits are payable (covered under provision L.14).

Outpatient office visit benefits are limited to payment for one visit per day per provider.

L.13 Medical/Dental Services for Accidental Injury to Teeth

(Certification requirement applies to inpatient services. See L.3 for coverage of non-certified hospital days.)

1. PROFESSIONAL SERVICES

Coverage includes professional services rendered by a physician, surgeon, or doctor of dental surgery for the treatment of a fractured jaw or other accidental injury to sound natural teeth, provided that:

a. the injury occurs while the patient is covered under the State Plan; or
b. the injury occurs while the patient is covered under creditable coverage as defined in Chapter 9. Such services shall be covered only during the 12-month period immediately following the date of injury.

Services for the treatment of accidental injury to teeth caused by biting or chewing are exclusions of this provision (they are covered under the Dental Plan, if enrolled).

Services and supplies provided by a hospital in conjunction with dental treatment will be covered only when a non-dental physical illness or injury exists which makes hospital care necessary to safeguard the member's health. Dental factors, such as complexity of dental treatment and length of anesthesia, do not make a dental treatment eligible for hospital benefits.

L.14 Maternity and Newborn Services

(Certification requirement applies to inpatient hospital stays. See L.3 for coverage of non-certified hospital days.)

1. MATERNITY CARE

Coverage includes hospital, physician, and certified licensed midwife services for the delivery or attempted delivery of one or more newborns, including prenatal and postpartum outpatient care and hospital services for conditions directly related to the pregnancy. Inpatient hospital care following delivery will be covered for the length of time medically necessary and will be at least 48 hours following a vaginal delivery and at least 96 hours following a Cesarean Section. The decision to shorten the length of inpatient stay to less than the above must be made by the attending provider and the mother.

Payment for any maternity services provided by a physician or licensed midwife is limited to the allowable fee for total maternity care, which includes delivery, prenatal, and postpartum care.

2. ROUTINE NEWBORN CARE

Coverage includes routine physician and laboratory care of a newborn at birth, standby care provided by a pediatrician at a Cesarean Section, and hospital nursery care of a newborn infant born in the hospital. The routine newborn care benefit is limited to three days of inpatient care. Additional hospital care required by a medical condition is covered under provision L.4.

L.15 Diagnostic/Laboratory Services

Coverage includes x-ray, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing accident or illness when hospital confinement is not required and benefits are not provided elsewhere in this Summary Plan Document.

X-ray and laboratory benefits shall not be provided for the following:

1. Dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident covered under L.13.
2. Visual examinations (covered under Section M).
3. Premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in L.36.

L.16 Radiation Therapy

Coverage includes x-ray, radium, or radioactive isotope therapy ordered by the attending physician and performed by a covered provider for the treatment of disease.

L.17 Chemotherapy

Coverage includes the use of chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, ordered by the attending physician, and administered by a covered provider for the treatment of disease.

L.18 Blood Transfusions

(Certification requirement applies to inpatient services. See L.3 for coverage of non-certified hospital days.)

Coverage includes blood transfusions, including the cost of blood and blood plasma, blood plasma expanders, and packed cells. Storage charges for blood are covered when you have blood drawn and stored for your own use for a planned surgery.

L.19 Medical Supplies

Coverage includes the following supplies, all for use outside a hospital:

1. Sterile dressings for conditions such as cancer or burns.
2. Catheters.
3. Splints and casts.
4. Colostomy bags and related supplies.
5. Supplies for renal dialysis equipment or machines.
6. Orthopedic braces, corsets, and trusses.
7. Syringes and diabetic supplies.
8. Oxygen and equipment for the administration of oxygen.

Medical supplies are covered only when both:

1. Medically necessary to treat a condition for which benefits are payable under this Summary Plan Document, and
2. Prescribed by a covered provider.

Syringes and diabetic supplies are also covered under the Prescription Drug Plan described in Section M.

L.20 Durable Medical Equipment and Prostheses

(Prior authorization is required for the initial purchase, or the repair and replacement of durable medical equipment or prostheses over $500. No benefit is available for expenses over $500 unless prior authorized.)

(Prior authorization is recommended for the original purchase, repair, or replacement of less expensive durable medical equipment or prosthetics to assure coverage. See Chapter 9 for a definition of durable medical equipment.)

Coverage includes the least expensive appropriate prosthetic device used to replace a body part missing due to accident, injury, or illness (such as artificial limbs or eyes), and the least expensive appropriate type of durable medical equipment necessary for therapeutic purposes in your home (such as crutches, a wheelchair, or a hospital-type bed).

DURABLE MEDICAL EQUIPMENT REQUIREMENTS

Durable medical equipment must meet the following criteria:

1. Able to withstand repeated use (consumables are not covered).
2. Primarily used to serve a medical purpose rather than comfort or convenience.
3. Generally not useful to a person who is not ill or injured.
4. Prescribed by a professional provider.

See the definition of durable medical equipment in Chapter 9 for examples of equipment that are not covered.

These devices and equipment shall be limited to those reasonably required by standard treatment practices as a result of injury of illness. Replacement of such devices and equipment shall be made only if the existing appliance cannot be made satisfactory by standard repair practices.

PRIOR AUTHORIZATION

You must obtain prior authorization from the indemnity medical plan's claims administration company for repair or replacement of durable medical equipment or a prosthesis that is over $500 (as well as initial purchase). Prior authorization may be obtained by submitting to the claims administration company the following:

1. A professional provider's prescription.
2. A written explanation by the professional provider as to why replacement is necessary.
3. An itemized repair and replacement cost statement from the provider.

THE FOLLOWING ARE NOT COVERED:

1. Durable medical equipment, orthopedic devices, or prosthetics required primarily for use in athletic activities.
2. Replacement of lost or stolen durable medical equipment, orthopedic devices, or prosthetics.
3. Repair to rental equipment.
4. Continuous passive motion devices, except in the case of surgery involving the knee joint, which begins within two days following surgery and is limited to:
   a. total knee replacement;
   b. repair of plateau fractures; and
   c. anterior cruciate ligament (ACL) repairs.
5. Duplicate equipment purchased primarily for patient convenience when the need for duplicate equipment is not medical in nature.
6. Expenses over $500 that are not prior-authorized.

L.21 Foot Orthotic Devices

Impression casting, orthotic devices, and corrective shoes for the treatment of malformation or structural weakness of the foot are covered, provided the device or corrective shoe is prescribed by a professional provider and custom built for the State Plan member. Allowable charges are limited to $100 per foot in any 12-month period.

L.22 Chemical Dependency Treatment

(Certification requirement applies to inpatient services. See L.3 for coverage of services for non-certified hospital days.)

Coverage includes outpatient visits (up to the annual visit limits described in the Annual Benefits Summary for the current benefit year) and inpatient treatment, up to a combined maximum dollar benefit defined in the Annual Benefits Summary (currently $6,000 for a 12-month period, until a $12,000 cumulative lifetime maximum benefit for inpatient treatment is met). If services are still required after the lifetime maximum benefit has been reached, an additional combined outpatient and inpatient annual benefit is available (currently $2,000). Residential care is not covered.

EAP SERVICES AND REFERRAL

The Employee Assistance Program offers a limited number of confidential counseling sessions at no cost to the State Plan member as described in the current Annual Benefits Summary. This is the lowest-cost source of assessment and treatment of chemical dependency. If additional services are needed, the EAP will make a referral to another appropriate provider.

You or an enrolled family member receive enhanced benefits for outpatient services when referred by the EAP. The number of outpatient visits covered per benefit year is higher, and the percentage of allowable charges you pay (your coinsurance) is lower, with an EAP referral. See the Annual Benefits Summary for the current benefit year for visit limits and coinsurance amounts with and without an EAP referral.

MEDICAL DETOXIFICATION

Treatment is covered the same as any other illness under the terms of this Summary Plan Document and is not subject to the annual and lifetime limits above.

COVERED PROVIDERS

Covered providers for the treatment of chemical dependency are facilities licensed by the state in which services are provided, such as a hospital or as a freestanding inpatient facility specializing in the treatment of chemical dependency; physicians; licensed social workers; and licensed addiction counselors.

L.23 MENTAL ILLNESS TREATMENT

(Certification requirement applies to inpatient services. See L.3 for coverage of services for non-certified hospital days.)

1. INPATIENT BENEFITS

Pre-certification (prior to admission) is strongly recommended to assure inpatient benefits. Costs for inpatient services can be expensive. Calling the State Plan's managed care company (at the number on your medical identification card) in advance of admission lets you know whether you meet plan criteria for inpatient coverage, and whether the intended mental health care facility's charges are within plan allowances. If you do not meet inpatient criteria, the managed care company can assist you with finding suitable alternatives such as partial hospitalization described below. If you do meet criteria, they can assist you in finding a mental health facility whose charges are covered by the State Plan.

Coverage includes medically necessary inpatient treatment of mental illness (as defined in Chapter 9) up to a maximum day limit specified in the Annual Benefits Summary for the current benefit year (currently 21 days per benefit year). This day limit does not apply to severe mental illness, as defined in Chapter 9.

2. PARTIAL HOSPITALIZATION BENEFITS

Prior authorization (prior to treatment) is strongly recommend to assure partial hospitalization benefits.

Partial hospitalization (intensive outpatient services defined in Chapter 9) for the treatment of mental illness may be exchanged for inpatient days at a rate of one inpatient day for two partial hospitalization days. A partial hospitalization program offers four to eight hours of therapy, five days a week. The hours of therapy per day and the frequency of visits per week will vary with each individual, depending on the clinical symptoms and progress being made.

3. OUTPATIENT BENEFITS

Coverage includes outpatient treatment of mental illness, reimbursed (after deductible) at the percentages specified in the Annual Benefits Summary for the current benefit year, up to the maximum number of visits per benefit year specified in the Annual Benefits Summary. The visit limit does not apply to severe mental illness defined in Chapter 9.

EAP Services and Referral

The Employee Assistance Program offers a limited number of confidential counseling sessions at no cost to the State Plan member, as described in the current Annual Benefits Summary. This is the lowest-cost source of assessment and treatment of mental illness. If additional services are needed, the EAP will make a referral to another appropriate provider.

You, or an enrolled family member, receive enhanced benefits for outpatient services when referred by the EAP. The number of outpatient visits covered per benefit year is higher, and the percentage of allowable charges you pay (your coinsurance) is lower with an EAP referral. See the Annual Benefits Summary for the current benefit year for visit limits and coinsurance amounts with and without an EAP referral.

4. COVERED PROVIDERS AND BENEFIT LIMITATIONS

Covered providers for the treatment of mental illness are facilities licensed by the state in which services are provided, such as a hospital specializing in the treatment of mental illness; licensed mental health treatment facilities; physicians / psychiatrists; licensed psychologists;

licensed professional counselors; and licensed psychiatric social workers.

Benefits do not include services rendered for learning disabilities; marital, family, or sexual problems; or for services excluded under the definition of mental illness in Chapter 9 (except for limited EAP benefits). Benefits also do not include custodial care, residential care, or training.

L.24 Severe Mental Illness Treatment

(Certification requirement applies to inpatient stays. Precertification is strongly recommend as described in L.23 to avoid extensive out-of-pocket costs if an inpatient stay fails to meet medical necessity criteria for coverage. See L.3 for coverage of services for non-certified hospital days. Prior authorization is strongly recommended for partial hospitalization services.)

Coverage includes medically necessary services provided by a licensed physician, licensed advanced practice registered nurse with prescriptive authority and specializing in mental health, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed physician. Residential care is not covered.

L.25 Home Infusion Therapy Services

Coverage includes medically necessary home infusion therapy services provided they are both:

1. ordered by a professional provider, and
2. provided by a licensed home infusion therapy agency.

Home infusion therapy services include:

1. Pharmaceuticals and supplies.
2. Equipment.
3. Skilled nursing services when billed by a home infusion agency. Services billed by a home health agency will be covered under your home health benefit in L.28.

L.26 Organ Transplants

Pre-certification (prior to admission) is strongly recommended. Organ transplants are one of the most costly medical procedures and State Plan members need to make sure they are covered. Also, the State Plan's managed care company can assist you in maximizing your benefits through the use of a hospital in the National Transplant Network provided by the claims administration company (as defined in Chapter 9). Hospitals in this network must meet selection criteria of a panel of nationally recognized transplant surgeons and offer an all inclusive package price for transplant services.

1. CORNEA AND KIDNEY TRANSPLANTS

(Certification requirement applies to inpatient services. See L.3 for coverage of services for non-certified hospital days.)

Coverage includes cornea and kidney transplants, including eye bank charges and initial allowable expenses associated with removing the organ from the donor, which are chargeable to the recipient State Plan member and are not covered by the donor's health plan.

Expenses for a State Plan member to donate a kidney or cornea to an individual who is not a State Plan member are not covered.

2. BONE MARROW, HEART, LUNG, AND PANCREAS

(Certification requirement applies to inpatient services. See L.3 for coverage of services for non-certified hospital days.)

Organ or tissue transplant services for a member who receives human-to-human organ transplants of bone marrow, heart, heart/lung, liver, lung, and pancreas are covered up to the lifetime maximum dollar allowance per transplant specified in the Annual Benefits Summary for the current benefit year. These allowances apply to charges related to the transplant for a period of 30 days before the transplant and extending for 18 months.

INCLUDED SERVICES

The following transplant-related services are covered under this provision (not other provisions of this Summary Plan Document) and are subject to the organ transplant lifetime dollar maximum:

1. Organ procurement, including the identification of an appropriate donor, transportation of the surgical/harvesting team, surgical removal of the do-

nor organ, evaluation of the donor organ, and transportation of the donor or donor organ to the location of the transplant.

2. Inpatient hospital services including room, board, and ancillaries.
3. Surgical services including a surgical assistant.
4. Anesthesia.
5. Outpatient services, including professional and diagnostic services.
6. Medically necessary licensed ambulance travel or commercial air travel for the recipient to the location of the transplant, or in the case of a medical emergency to the nearest hospital with appropriate facilities.

BENEFITS ARE NOT PROVIDED FOR THE FOLLOWING:

1. Services not ordered by two board certified specialists.
2. Transplants of a non-human organ or artificial organ implant.
3. Charges for lodging and meals.
4. Experimental or investigational procedures.
5. Expenses for a State Plan member to donate an organ or portion of an organ to an individual who is not a State Plan member.

L.27 TRANSPORTATION

Coverage includes one-way out-of-state transportation by regularly scheduled passenger aircraft, railroad, bus, or round-trip mileage at the normal state reimbursement rate for travel by personal automobile inside the United States and Canada to (or from) the nearest medical facility equipped to provide the necessary treatment not available in a Montana facility. Transportation for treatment at in-state facilities is not covered.

Transportation benefits are limited to the following circumstances:

1. A life-endangering situation exists that requires immediate transfer to or from a hospital that has special facilities for treatment of the condition.
2. Treatment is needed that cannot be performed in state as determined by the State Plan's claims administration company, based on claim information or information on the prior authorization form, described below.

Transportation benefits in any one benefit year shall be limited to one-way transportation (except round-trip mileage at the normal state reimbursement rate for travel by personal automobile) for:

1. One visit for treatment or surgery and one preparatory or follow-up visit for a condition which cannot be treated in state.
2. One visit for each allergic condition which cannot be treated in state.

If the patient is a child under 18 years of age, the transportation charges of a parent or legal guardian may be allowed if the attending physician certifies the need for such attendance. Transportation charges for a physician or a registered nurse to accompany the member may be covered only when determined necessary by the claims administrator.

TRAVEL PRIOR-AUTHORIZATION

Plan members can determine whether expenses for non-emergency transportation will be approved in advance by completing a Travel Prior-Authorization Application Form, and submitting it to the State Plan's claims administration company for a determination. This form is available from the State Plan' claims administration company.

L. 28 HOME HEALTH SERVICES

Prior authorization (prior to services) is strongly recommend to assure coverage.

Coverage includes the following services and supplies furnished by a licensed home health agency in a member's home in accordance with a professional provider's written home health care treatment plan for the treatment of injury or illness:

1. Part-time or intermittent nursing care by an RN or LPN.
2. Part-time or intermittent home health aid services.
3. Physical, occupational, and speech therapy.
4. Medical supplies suitable for use in the home.

Home health services are limited to the number of days specified in the Annual Benefits Summary for the cur-

rent benefit year (currently 70 days of service during any one benefit year). Home health aide services in excess of four hours in any one day shall be considered an additional day.

Home health expenses are not payable for:

1. Services or supplies not included in the home health care plan of treatment.
2. Domestic or housekeeping services, including such programs as "Meals-on-Wheels."
3. Services received in a nursing home or skilled nursing facility (covered under L.30).
4. Services for mental or nervous conditions.
5. Services of a social worker.
6. Transportation services.
7. Durable medical equipment and prostheses (covered under L.20).

L.29 Hospice Services

Coverage includes services of a hospice facility, agency, or service and are subject to the following conditions:

1. The services are medically necessary.
2. They are ordered by a physician.
3. The member is terminally ill and expected to live no more than six months.

Covered hospice services are as follows:

1. Home health care services listed above.
2. Services of a social worker (M.S.W.).
3. Bereavement follow-up care provided by a Social Worker (M.S.W.) employed by the home health agency, limited to two visits per family following the member's death.

Hospice benefits are not provided for the following:

1. Care for which no charge would customarily be made if insurance coverage did not exist.
2. Patient expenses incurred more than six months after the first charge for hospice care is incurred.
3. Transportation services.
4. Durable medical equipment and prostheses (covered under L.20).

L.30 Skilled Nursing Facility Care

Prior authorization (prior to services) is strongly recommend to assure coverage of services.

Coverage includes medically necessary skilled nursing facility care, as defined in Chapter 9, for up to the number of days specified in the Annual Benefits Summary for the current benefit year (currently 70 days per benefit year) during convalescence or recovery from illness or injury. Custodial care is not covered, nor are confinements for mental illness and chemical dependency. Confinements must be recommended by the attending physician. Benefits will no longer be provided when confinement ceases to be rehabilitative and becomes custodial in nature.

L.31 Rehabilitation Therapy

(Certification requirement applies to inpatient services and pre-certification (prior to admission) is strongly recommended. See L.3 for coverage of services for non-certified hospital days.)

(Prior authorization (prior to services) is required for intensive outpatient rehabilitation therapy benefits which exceed the dollar limit on standard outpatient rehabilitation benefits (specified in the current Annual Benefits Summary).

INPATIENT REHABILITATION THERAPY

Coverage includes inpatient rehabilitation therapy (physical, occupational, and speech therapy as defined in Chapter 9) for up to the number of days specified in the Annual Benefits Summary for the current benefit year (currently 60 days per benefit year) which meets the following critieria:

1. Provided by a multi-disciplinarian team under the direction of a physician.
2. Medically necessary to improve or restore bodily function.
3. Producing measurable progress.
4. Required because the nature of the treatment (frequency, duration and/or variety) or the physical condition of the patient makes outpatient treatment an unrealistic alternative.
5. Rendered in a licensed rehabilitation care facility.

OUTPATIENT REHABILITATION THERAPY

Coverage includes outpatient physical, occupational, and speech rehabilitation therapy services which meet the following criteria:

1. Prescribed by a licensed physician or mid-level practitioner within the last six months (after six months a new order or referral is required).
2. Provided by a licensed physical, occupational, or speech therapist.

Benefits for all rehabilitation therapy are limited to the annual dollar maximum shown in the Annual Benefits Summary for the current benefit year — unless the therapy qualifies as Intensive Outpatient Rehabilitation, described below:

INTENSIVE OUTPATIENT REHABILITATION THERAPY

(Prior authorization required for benefits in excess of the standard outpatient rehabilitation benefit.)

Coverage includes intense treatment involving at least two modalities, two or three hours per day, three to five times per week for an extended duration of three to six months for a severe injury or medical condition (such as brain injury) which requires extended rehabilitation following hospitalization or which meets criteria for inpatient rehabilitation therapy. Benefits for intensive outpatient therapy are limited to an annual dollar maximum shown in the Annual Benefits Summary for the current benefit year.

No rehabilitative therapy benefits are provided for the following:

1. Custodial care.
2. Diagnostic admissions.
3. Maintenance, non-medical self-help, or vocational education therapy.
4. Learning or developmental disabilities.
5. Social or cultural rehabilitation.
6. Visual, speech, or auditory disorders.
7. Treatment for chemical dependency or mental illness (covered under L.22, L.23, and L.24).

L.32 ALTERNATIVE HEALTH CARE

Covered services include acupuncture and chiropractic treatments when performed by a licensed chiropractor, licensed naturopath, or licensed acupuncturist practicing within the scope of his/her license.

The services defined above must meet the following definitions:

1. Therapeutic care — treatment considered necessary to return the member to a pre-clinical status or establish a stationary status.
2. Palliative care — treatment affording relief, but no cure.

Alternative health care services are limited to the combined maximum number of visits per benefit year and the per-visit dollar maximum specified in the Annual Benefits Summary for the current year.

Benefits are not provided for the following:

1. Maintenance — a regime designed to provide an optimum state of health while minimizing recurrence of clinical status.
2. Preventive treatment — procedures necessary to prevent the development of clinical status.
3. Self-help programs.
4. Holistic medicine.
5. Rolfing or massage therapy.
6. Stress management.
7. Hypnotherapy.
8. Homeopathy.
9. Naturopathic services not specifically covered in this Summary Plan Document.

L.33 INBORN ERRORS OF METABOLISM (INCLUDING PKU)

Coverage includes treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist.

L.34 Medical Eye Care

(Certification requirement applies to inpatient services. See L.3 for coverage of non-certified hospital days.)

Coverage includes services of a licensed physician and those services of an optometrist, which are within the scope of his or her licensure, for the medical treatment of disease or injury to the eye.

Routine vision exams, glasses, and laser surgery to correct vision are not benefits of this medical plan (see Section M).

L.35 Infertility Treatment

(Certification requirement applies to inpatient services. See L.3 for coverage of non-certified days. Prior authorization required for benefits.)

Coverage includes diagnostic and evaluation services to determine fertility state. For members diagnosed as biologically infertile, one attempt at in-vitro fertilization, including sperm washing, is allowed per member per lifetime provided:

1. all less-costly reasonable treatments have failed, and
2. the service is prior authorized by the State Plan's claims administration company.

Required prescription drugs are covered by the Prescription Drug Plan when prior-authorized as described in K.4.

L.36 Preventive Services

1. WELL CHILD SERVICES

a. Coverage includes well-child services through the age of 5, including examination by a physician or physician's assistant (medical history, physical examination, developmental assessment, and anticipatory guidance), at approximately the following ages:
   1) a visit for any newborn who was discharged from a hospital in less than 36 hours;
   2) one month of age;
   3) two months of age;
   4) four months of age;
   5) six months of age;
   6) nine months of age;
   7) 12 months of age;
   8) 15 months of age;
   9) 18 months of age;
   10) 24 months of age; and
   11) above 24 months as prescribed by the following provisions:

b. Laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in MCA 53-6-101; and

c. Routine immunizations according to the schedule of immunizations recommended by the Immunization Practices Advisory Committee of the United States Department of Health and Human Services.

Payment will be made according to the Annual Benefits Summary for the current benefit year. Services received through a county health department are reimbursed at 100 percent. No payment will be made for duplicate services with respect to any scheduled visit.

2. ADULT PREVENTIVE SERVICES

Coverage includes gynecological exams, mammograms, PSA tests, bone density tests, proctoscopic exams, and sigmoidoscopies or colonoscopies when provided by a covered provider within the scope of the provider's license, subject to the limitations specified in the Annual Benefits Summary for the current benefit year. These are currently as follows:

a. one routine gynecological exam, with or without a pap smear, per benefit year;

b. one routine mammogram for women ages 35-39, one every 24 months for ages 40 through 49, and one every 12 months after age 50;

c. two routine PSA (prostate-specific antigen) tests for men ages 40 to 50, and one every year for men older than age 50;

d. two bone density tests (dexa scans) per lifetime; and

e. two routine proctoscopic exams from ages 40 to 50, and one every 36 months after age 50, including sigmoidoscopy or colonoscopy, and limited to the dollar maximum specified in the Annual Benefits Summary for the current benefit year.

No payment will be made for duplicate services with respect to any scheduled visit.

3. HEALTH SCREENING

Coverage includes services provided by health care providers who have a contract with the State of Montana

to provide this benefit. These services are covered benefits for the duration of the contract with providers and are paid at 100 percent for eligible state employees and retirees. A spouse may participate by self-paying the costs.

Health screening services include blood analysis, blood pressure check, health risk appraisal, body weight and percent body fat assessment, and hemoccult tests subject to the following limitations:

a. screenings are limited to one every two years for eligible participants;
b. hemoccult tests are limited to participants ages 50 and over and participants with colon cancer risk factors; and
c. the provider will collect the screening fee from ineligible participants.

L.37 Limited Dietary Counseling and Obesity Treatment

(Prior authorization required for obesity treatment benefits.)

1. DIETARY COUNSELING

Coverage includes limited dietary counseling services of a registered dietician or other covered provider licensed to provide dietary counseling services, when ordered by a physician. The dietary counseling services must be needed for reasons other than obesity (unless part of the treatment plan described below for morbid obesity) or routine vitamin supplementation. See the current Annual Benefits Summary for the dollar limit on this benefit.

2. MORBID OBESITY TREATMENT

Coverage includes a once-per-lifetime, non-surgical benefit for morbid obesity, defined in Chapter 9, under a prior-authorized, physician-directed treatment plan. Timely progressive weight loss is required for benefit continuation.

L.38 Birth Control

Coverage includes birth control medications and supplies, other than oral contraceptives (covered under Section K), when a prescription is required including: Norplant, Depoprovera, diaphragms, IUDs and the fitting or administration of such.

L.39 Care Management Services

Care management services are contractual services to assist indemnity medical plan members navigate the health care and health insurance systems to receive the care they need and minimize their costs. These services are provided, at no cost to State Plan members, by physicians and registered nurses with the State Plan's managed care company. State Plan members are encouraged to use the following services:

1. HOSPITAL CERTIFICATION SERVICES (DESCRIBED IN G.4)

Hospital admissions called in to the State Plan's managed care company for certification as described in G.4 are reviewed to let indemnity medical plan members know in advance of the admission (or as soon after an emergency admission as possible) whether the admission and the intended number of hospital days meet medical necessity criteria defined in L.2 to receive standard benefits. Inpatient hospital days must be certified as medically necessary to receive standard benefits. See. L.3 for coverage of non-certified days.

On the last certified day of your hospitalization, a managed care nurse will contact the hospital to check on your status. Should you need to remain hospitalized longer than originally certified, the hospital or your doctor will be contacted for additional information and any additional medically necessary days will be certified.

Certification only provides assurance that medical necessity criteria have been met. Payment depends upon other factors such as whether a particular service is a covered benefit of your indemnity medical plan, whether you are an eligible member, whether a pre-existing waiting period applies, etc. You may obtain a prior authorization (described in G.5) to determine if a particular procedure is covered or a pre-determination (described in G.3) to determine what the plan payment and your remaining payment will be. These services are available from your claims administration company at the phone number listed on your medical identification card.

2. BENEFIT COORDINATION SERVICES

Benefit coordination services are available from the managed care company when an indemnity medical plan member requests assistance in exploring outpa-

tient alternatives to hospitalization or continued hospitalization, or when inpatient hospital days are not certified as medically necessary. This service is voluntary, free of charge, and available to help members understand their treatment options, plan benefits, and what options are available to reduce their out-of-pocket costs. In some cases, the managed care company may be able to work with you and your attending physician to help obtain needed medical equipment and customized treatment services. Call the customer service number on your medical identification card and ask for the State Plan's managed care company to access this benefit.

3. FOCUSED CASE AND DISEASE MANAGEMENT

Focused case and disease management services are provided by health care professionals (physicians and registered nurses) with the State Plan's managed care company. Case management nurses work with members who can benefit from case management services, their attending physician, and their family to identify and arrange the most appropriate, effective, and cost-efficient treatment possible.

Services are focused on indemnity medical plan members identified as having:

a. a catastrophic illness or injury which can benefit from case management; or
b. significant medical risks or chronic health care needs, which can be reduced through prevention or disease management.

At-risk members and members with a catastrophic illness injury will be identified through analysis of information called in for pre-certification of inpatient hospitalization and medical and pharmaceutical claims data to determine who is most likely to benefit from case management services. You or an adult family member enrolled in a state indemnity medical plan will be individually contacted by a nurse reviewer if you (or the enrolled family member) qualify. Contract provisions require that the managed care company which provides these services keep all claims data and other medical information strictly confidential. When offered focused case or disease management services, members are encouraged to give them careful consideration, but are free to reject some or all proposals or advice.

Use of case or disease management services is voluntary, free of charge to the State Plan member and helpful in several ways:

a. it permits treatment options not normally available under the State Plan through plan exceptions (see T.11); and
b. it saves both the State Plan and its member money by providing a third party to help identify the more efficient/lower cost suppliers of medical goods and services, coordinate services, work out cost reductions, and make arrangements for special treatment plans.

4. MATERNITY CASE MANAGEMENT

Maternity case management is also voluntary and free of charge to the member. The goal is to encourage pregnant members to receive the prenatal care and education needed for a healthy pregnancy and infant.

To participate in this program, call the state's managed care company at the number listed on your medical identification card within the first trimester. The initial screening phase of the program will be handled by phone. If you call in a pregnancy in the first trimester, you will receive prenatal vitamins free of charge. You will be encouraged to participate in a more in-depth assessment to identify any potential risks. If risks are identified, a case management nurse will work with you, your family physician, and other care providers to develop a care plan, which will allow for the best possible outcome of a high-risk pregnancy.

You should also call, or make sure the hospital calls, the managed care company for certification of inpatient hospital days when admitted for delivery, as described in G.4 and L.14.

L.40 EXCLUSIONS AND LIMITATIONS

The following services and expenses are not covered:

1. Hospitalization for days that are not certified as medically necessary for the therapeutic treatment of an injury or illness, except as specified in L.3. This includes the following:
   a. hospitalization for diagnostic tests, observation, or examinations when treatment does not require bed patient care.
   b. hospitalization for physical therapy or inhalation therapy when treatment does not require bed patient care.
   c. hospitalization including any services furnished by an institution which is primarily a place for

rest, a place for the aged, a nursing home, or any similar institution.

d. any other hospitalization which is not medically necessary as described in Chapter 9.

2. Services for which the member is not legally required to make payment or for which charges are made only because the member has benefits under the State Plan. Benefits are not provided for expenses dismissed by professional or courtesy discounts.

3. Services and supplies which you or a dependent member are entitled to receive or do receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government.

Related Information

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your State Employee Benefits Plan. When such a circumstance occurs, you will receive an Explanation of Benefits.

4. All services and supplies which are provided to treat any illness or injury arising out of employment when your employer has elected or is required by law to obtain coverage for such under state or federal Worker's Compensation laws, occupational disease laws, or similar legislation, including employee's compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such illness or injury even though the following apply:

   a. Coverage under the government legislations provides benefits for only a portion of the services incurred.

   b. Your employer has failed to obtain such coverage as required by law. This exclusion does not apply if your employer was not required and did not elect to be covered under any Worker's Compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States.

   c. The member waives his or her rights to such coverage or benefits.

   d. The member fails to file a claim within the filing period allowed by law for such benefits.

   e. The member fails to comply with any other provision of the law to obtain such coverage or benefits.

   f. The member was permitted to elect not to be covered by the Worker's Compensation Act, but failed to properly make such election effective. This exclusion will not apply if you are permitted by statute not to be covered and you elect not to be covered by the Workers Compensation Act, occupational disease laws, or liability laws.

5. Expenses that a member is entitled to have covered, or that are paid under an automobile insurance policy, a premise liability insurance policy, or other liability insurance policy. This includes, but is not limited to, a homeowner's policy or business liability policy, or expenses that the member would be entitled to have covered under such policies if not covered by the State Plan.

6. Services or procedures that are:
   a. not medically necessary to treat active illness or injury, or specifically listed as a benefit;
   b. not generally accepted by the medical profession; and
   c. experimental procedures, as defined in Chapter 9, which are for research. The State Plan may consult with physicians or national medical specialty organizations for advice in determining whether the service or supply is accepted medical practice.

7. Treatment of mental, psychoneurotic and personality disorders, chemical dependency disorders, adolescent behavior problems, learning disabilities, and family, marital or sexual problems — except as provided in L.22, L.23, and L.24 and by the Employee Assistance Program described in Section M.

8. Routine physical examinations and immunizations including premarital, insurance, athletic, school entrance and employment physicals or immunizations, except services specifically covered under L.36.

9. Treatment of a condition caused by or arising out of an act of war (declared or undeclared), insurrection, rebellion, or armed invasion.

10. Any expense for which a contributing cause was commission by the member of a criminal act, attempt to commit a felony, or to which the contrib-

uting cause was the member's being engaged in a illegal occupation.

11. Vision examinations (may be covered under a separate vision exam plan described in Section M), hearing examinations, corrective appliances, and laser eye surgery. Corrective appliances include glasses, contact lenses, and hearing aides.

12. Orthoptics or vision training.

13. Treatment for obesity, including surgery and complications, except for the limited once-per-lifetime, non-surgical benefit for morbid obesity described in L.37.

14. Dental care, including dental services listed as exclusions of the Dental Plan, with the following exceptions:
    a. treatment required due to injury to sound natural teeth described in L.13; and
    b. treatment required due to a dependent child's congenital abnormality, provided the child was born and enrolled while the employee was a member of the State Plan or covered under creditable coverage as defined in Chapter 9.

15. Speech therapy, except as provided in L.31.

16. Elective abortion.

17. Cosmetic surgery, services, or supplies except treatment or surgery due to a dependent child's congenital abnormality, provided the child was born and enrolled while the employee was a member of the State Plan. Cosmetic surgery is surgery which improves appearance or corrects a deformity without restoring a physical function of the body. Some procedures are usually cosmetic but may not always be. In these cases prior authorization described in G.5 is strongly recommended to assure coverage.

18. Any foot orthotic and foot care, except as provided in L.21, including the following:
    a. removal or treatment of corns or callosities.
    b. hyertrophy, hyperplasia of the skin, or subcutaneous tissues.
    c. cutting or trimming of nails.
    d. treatment of flat feet, fallen arches, or chronic foot strain.
    e. orthotic appliances and casting for orthotic appliances, except as provided in L.21.
    f. padding and strapping.
    g. fabrication.

19. Medical or surgical reversal of elective sterilization and experimental fertility procedures.

20. Treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements and myofascial pain syndrome, or orthodontics (dentofacial orthopedics) or related appliances. Surgical treatment for these conditions will be allowed only if prior authorized by the State Plan's claims administration company.

21. Organ or tissue transplants, except as provided in L.25 and L.26.

22. Humidifiers, air conditioners, exercise equipment, home traction units, whirlpools, health spas or swimming pools, whether or not prescribed by a professional provider.

23. Implantable and/or inflatable prosthesis.

24. Services and supplies related to sexual inadequacy or dysfunction, or sexual transformations and reversals of such procedures.

25. Personal services such as radio, television, and phone service.

26. Sanitarium care, custodial care, rest cures, or convalescent care to help you with daily living tasks such as: walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparing special diets, and supervising medications which are usually self-administered.

27. Health clubs, health spas, and exercise programs, whether or not approved or prescribed by a professional provider.

28. Any expense incurred after group coverage terminates.

29. Education or tutoring services, except as specifically included as a benefit of state indemnity medical plans in this Summary Plan Document.

30. Any facility charges for chronic pain management services provided by an inpatient pain center.

31. Services and supplies related to any of the following treatments or related procedures:
    a. self-help programs;
    b. religious counseling;
    c. marriage counseling (see Section M for Employee Assistance Program coverage);
    d. holistic medicine;
    e. rolfing;
    f. stress management;
    g. hypnotherapy;
    h. homeopathy; and
    i. naturopathic services not otherwise covered in this Summary Plan Document

32. Services and supplies primarily for personal comfort, hygiene, or convenience, which are not primarily medical in nature.

33. Travel for a member or provider, unless specifically covered as a benefit of this Summary Plan Document.

34. Private duty nursing, except as specifically included as a benefit of this Summary Plan Document.

35. Any additional charge for inclusive procedures or services as defined in Chapter 9 and as determined by the State Plan's claims administration company.

36. Services or supplies for complications resulting from services that are not covered.

37. Services and supplies not provided by a covered provider or which are not listed as a benefit of state indemnity medical plans in this Summary Plan Document.

38. Residential care services, boot camps, or rehabilitative schools.

M. MISCELLANEOUS BENEFITS

M.1 Optional Vision Insurance

Members who are enrolled in the optional Vision Insurance Plan are entitled to the following:

1. Periodic eye examinations from a participating provider, or a periodic allowance toward an exam from a non-participating provider, as defined in the current Annual Benefits Summary.
2. A periodic set of lenses, including single vision, lined bifocal, and lined trifocal lenses from a participating provider, or a periodic allowance toward a set of these lenses from a non-participating provider, as defined in the current Annual Benefits Summary.
3. A periodic dollar allowance toward frames, as defined in the current Annual Benefits Summary.
4. As an alternative to lenses and frames, a periodic allowance toward a contact lens exam and contact lenses, as defined in the current Annual Benefits Summary.
5. Preferred pricing (discounts) for covered services from participating providers including:
   a. a contact lens exam for assessment of suitability for, and fitting of, contacts;
   b. a year's supply of contacts from the vision insurance company;
   c. costs of additional lens options in excess of allowances for lenses listed above (such as progressive lenses); and
   d. frame costs in excess of allowance, all as defined in the current Annual Benefits Summary.
6. Preferred pricing (discounts) for additional non-covered vision services from participating providers, including:
   a. a contact lens exam, even though the vision coverage was used for glasses;
   b. a year's supply of contacts from the vision insurance company, even though the vision coverage was used for glasses;
   c. extra pairs of prescription glasses, including prescription sun glasses; and
   d. laser surgery at participating centers, all as defined in the current Annual Benefits Summary.

See the current Annual Benefits Summary for updates on covered services, frequency of coverage, dollar allowances, and copayment amounts. Also see the current Annual Benefits Summary for the current vision insurance company and the web site where you can find participating providers in your area. See I.1 for information on obtaining benefits and Chapter 1 on enrollment.

M.2 Employee Assistance Program (EAP)

All State Employee Benefit Plan members, and members of their immediate family, are entitled to the number of free counseling visits per benefit year specified in the current Annual Benefits Summary. Managed care plan members do not need a referral to receive free EAP visits.

Visits must be with counselors who are participating providers of the EAP administrator. Participating counselors are licensed and hold at least a Master's degree in their field.

Counseling may include a broad range of issues such as depression, family or marital difficulties, money management, grief, coping with stress, alcohol or drug addiction, and work-related problems. All visits are completely confidential. Legal consultation and referral, as well as financial consultation, may also be available as specified in the current Annual Benefits Summary. See the current Annual Benefits Summary for the current EAP administrator and the web site where you can find participating counselors.

ENHANCED INDEMNITY MEDICAL PLAN BENEFITS WITH AN EAP REFERRAL

If a member needs longer-term counseling or a higher level of care than is available through the EAP, the EAP counselor will initiate a referral for the appropriate care. If the member is on the indemnity medical plan and the referral care is covered, enhanced benefits may be available. A greater number of mental health and chemical dependency visits are covered and the member's coinsurance is reduced with an EAP referral as specified in the current Annual Benefits Summary. For managed care plan members, the referral requirements of their plan apply.

CRISIS AND PHONE ASSISTANCE LINE

If you, or a member of your family, is in crisis or just want someone to talk with quickly and confidentially, you or your family member may call the EAP's 800 number, also available in your current Annual Benefits Summary.

CHAPTER 4
DENTAL BENEFITS

N. DENTAL BENEFITS AND EXCLUSIONS

N.1 Covered Dental Expenses

Expenses covered by the Dental Plan are:

1. expenses within allowable charges. (You are responsible for expenses over allowable charges unless you use a participating provider — see G.1 and G.2 of Chapter 2.);
2. expenses within specified benefit limitations contained in this chapter and which meet other requirements of this Summary Plan Document; and
3. expenses for covered dental services, defined below.

N.2 Covered Dental Services

Covered dental services are services, procedures, or supplies that are:

1. listed in sections N. 4 – N.6 of this Summary Plan Document and not excluded in N.7;
2. provided to a member by a covered provider; and
3. provided and coded in accordance with applicable dental policy.

N.3 Covered Dental Expenses You Pay

You pay the coinsurance listed in the Annual Benefits Summary for the current benefit year for each of three types of covered services:

Type A – Preventive Services
Type B – Basic Services
Type C – Extensive Services

Types B and C also have a deductible ($50 at the time of this publishing) that must be met before the plan reimburses.

All services are subject to a $1,000 annual benefit maximum.

N.4 Type A – Covered Preventive Services

1. Diagnostic – Dental x-rays are limited to one full-mouth x-ray or series in any period of three years, and not more than two sets of supplementary bitewing x-rays in any benefit year.
2. Preventive – Oral examination, including prophylaxis (cleaning), limited to two examinations and/or applications in any benefit year, and for enrolled children under the age of 16, topical application of fluoride.
3. Emergency Pain Relief – Unscheduled minor emergency treatment to relieve pain. Type B and C services are not minor treatment procedures for purposes of this provision, except palliative treatment and an emergency examination.

N.5 Type B – Covered Basic Services

Covered basic services include:

1. Passive space maintainers.
2. Extractions.
3. Fillings consisting of silver, amalgam, silicate, and plastic. Two or more fillings on the same surface are considered as one procedure even though the fillings are not in contact with each other.
4. Mucogingivoplastic surgery, management of an acute infection, and oral lesions.
5. Endodontics – The diagnosis and treatment of disease of the dental pulp. This includes:
   a. removal of tooth pulp;
   b. pulp capping;
   c. root canal treatment; and
   d. retrograde procedures.
6. Periodontics – The diagnosis and treatment of diseases of tissues around the teeth. This includes:
   a. gingival and osseous surgery;
   b. periomaintenance;

c. periodontal scaling; and
d. root planing.

7. Oral surgeries that are not covered under Chapter 3 – Medical Benefits.

The types of surgeries which are excluded from dental benefits because they are considered medical procedures are listed in N.7, provision l.

8. General anesthesia (prior authorization recommended to assure coverage) performed by a physician/anesthesiologist, dentist (other than the attending dentist), or by a nurse anesthetist for oral surgery, teeth extraction, or when certified as medically necessary by the attending dentist.

N.6 Type C – Covered Extensive Services

Type C services (except replacement dentures) are payable after 12 months of continuous coverage under the State Plan. Replacement dentures are payable after 36 months of continuous coverage. Waiting periods may be eliminated or reduced by creditable coverage (see C.5).

Coverage includes:

1. Single restoration (temporary and permanent) crowns, bridge abutments (bridge retainers - crowns), inlays, onlays, pontics (wire attachment to sound teeth for a bridge) and gold and porcelain fillings. Replacement of crowns is limited to once every five years.

2. Bridges, limited to no more than one replacement every five years.

3. Repair, relining, and rebasing of existing dentures which have not been replaced by a new denture.

4. Initial dentures and replacement dentures, limited to no more than one set of replacement dentures every five years. (This limitation is waived in the case of damage through accidental injury to the mouth described below.) Adjustment of bridges or dentures is covered only after six months of use of the appliance.

Accident Waiver of Waiting Periods on Replacement Dentures

The waiting periods will be waived for Type C services which are required to repair or replace dentures or other attachments damaged during accidental injury to the mouth and which are not covered by L.13. They will only be waived for repair or replacement of dentures or other removable attachments if damage occurred while they were in the mouth and there is other injury to the mouth requiring treatment.

5. Dental implants (devices surgically inserted into the jawbone) for an edentulous mouth are limited to a maximum benefit of $10,000 per lifetime when:
   a. the member has an edentulous mouth (no teeth in an arch or in the entire mouth); and
   b. the member has no ability to use customary prosthodontic appliances or devices, such as dentures. (Prior authorization is required as specified below.)

Implant Benefits Include:

a. Any necessary buildup of the dental ridge by bone interface material such as, but not limited to, hydroxyapatite. The necessity for the bridge augmentation must be documented;
b. implant procedure; and
c. removable prosthesis that sets over the implants.

Bone grafts, anesthesia, and hospitalization related to endentulous implants will be subject to and paid according to medical benefit provisions (see Section L, or for members on a managed care plan, that plan's Managed Care Plan Supplement to Section L). Absent medical health care coverage, these services will be covered under the Dental Plan as Type C services, subject to the $10,000 lifetime maximum as well as a $1,000 yearly dental maximum.

Maintenance and care of the implant(s), such as cleaning or periodontal services, are covered under prosthodotic, endodontic, and periodontic service provisions.

Prior Authorization Must Include:

a. A written narrative showing the proposed treatment is necessary;
b. an estimated cost of the proposed treatment; and
c. panoramic x-ray and study models demonstrating the status of the member's endentulous mouth.

6. Limited dental implants benefits in lieu of, and up to, the amount allowed (allowable fee) for a bridge or partial denture, to replace single or multiple missing teeth. The allowance may be applied to crowns, a partial denture, or a fixed bridge denture that fits over the implant. Prior authorization is required.

7. Dental sealants, limited to enrolled dependents under age sixteen (16), applied to molars once per tooth per lifetime. Repair and resealing are not covered.

N.7 Exclusions and Limitations

Dental benefits shall not be provided for the following services and expenses:

1. Expenses covered under Chapter 3 – Medical Benefits, whether or not they are paid in whole or in part. This includes:
   a. dental care required because of accidental injury to sound natural teeth (see L.13);
   b. removal of cysts, tumors, neoplasms, inflammatory lesions, and scar tissue from the mouth;
   c. surgery to drain abscesses;
   d. treatment of bone fractures; and
   e. the repair of traumatic wounds to the mouth.

   If you have questions about whether a particular surgical procedure is a medical procedure (payable only if you are enrolled for medical benefits and subject to deductible), or a dental procedure (payable only if you are enrolled for dental benefits and not subject to a deductible), please call the State Plan's claims administration company at the number on your identification card.

2. All services and supplies which are provided to treat any illness or injury arising out of employment when your employer has elected or is required by law to obtain coverage for such under state or federal worker's compensation laws, occupational disease laws, or similar legislation, including employee's compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such illness or injury even though the following apply:

   a. Coverage under the government legislations provides benefits for only a portion of the services incurred.

   b. Your employer has failed to obtain such coverage as required by law. This exclusion does not apply if your employer was not required and did not elect to be covered under any worker's compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States.

   c. The member waives his or her rights to such coverage or benefits.

   d. The member fails to file a claim within the filing period allowed by law for such benefits.

   e. The member fails to comply with any other provision of the law to obtain such coverage or benefits.

   f. The member was permitted to elect not to be covered by the Worker's Compensation Act, but failed to properly make such election effective. This exclusion will not apply if you are permitted by statute not to be covered and you elect not to be covered by the Workers Compensation Act, occupational disease laws, or liability laws.

3. Services for which the member is not legally required to make payment or for which charges are made only because the member has benefits under the State Plan. Benefits are not provided for expenses dismissed by professional or courtesy discounts.

4. Dental services which do not have uniform professional endorsement, are experimental, or for research.

5. Any expense for which a contributing cause was commission by the member of a criminal act, attempt to commit a felony, or the member's engagement in an illegal occupation.

6. Treatment of a condition caused by or arising out of an act of war (declared or undeclared), insurrection, rebellion, or armed invasion.

7. Dental treatment while in active military service.

8. Charges for services which are normally included in the basic charge, such as local anesthesia.

9. Treatment by someone other than a dentist, oral surgeon, or licensed denturist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hy-

gienist if the treatment is rendered under the supervision and guidance of the dentist.

10. Services beyond the scope of a covered provider's license.
11. Any service or supplies for congenital malformation, whether or not they are covered benefits under Chapter 3 (see L.40, provision 14).
12. Services or supplies which are for orthodontic treatment, except for extractions incidental thereto.
13. Precision or other elaborate attachments for any appliance.
14. Habit appliances and patient education, including instructions for plaque control or oral hygiene.
15. Surgical implants and precision or semi-precision attachments of any type, except services described in N.6, provisions 5 and 6.
16. Bite registrations and splinting.
17. Sealants to prevent decay, including fissure sealants, unless for an enrolled dependent under age 16 (see N.6, provision 7).
18. Non-surgical treatment for malocclusion of the jaw, including services for temporo-mandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements and myofascial pain syndrome, or orthodontics (dentofacial orthopedics) or related appliances (see L.40, provision 20).
19. Ridge augmentation, except as noted under N.6, provision 5.
20. Hospitalization for dental services. If hospitalization is medically necessary it is covered under the medical plan.
21. Services or supplies which are cosmetic in nature.
22. Services, appliances, or restorations used primarily to increase vertical dimensions or to restore occlusion.
23. Services or supplies for complications resulting from services that are not covered — including the removal of dental implants and the treatment of complications of the implant procedure — unless the implant met the requirements of N.6, provision 5. This includes the requirement that the edentulous status of the mouth and inability to support dentures without implants be established during a prior authorization process.
24. Services and supplies which you or a dependent member are entitled to receive or do receive from the United States or any city, county, state, or country. This exclusion applies to any programs of any agency or department of any government.

Related Information

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your State Employee Benefits Plan. When such a circumstance occurs, you will receive an Explanation of Benefits.

25. Any expense incurred after group coverage terminates.
26. Any additional charge for inclusive procedures or services as defined in Chapter 9 and as determined by the State Plan's claims administration company.

CHAPTER 5
LONG-TERM CARE INSURANCE, LIFE INSURANCE, AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE BENEFITS

O. LONG-TERM CARE INSURANCE

O.1 Long-Term Care Benefit Options

Eligible employees and their spouses, parents, parents-in-law, grandparents, or grandparents-in-law, and retirees and their spouses (all through the age of 84), may apply for long-term care insurance coverage from the State Plan's long-term care insurance company as described in Chapter 1. Benefit options include:

1. CARE OPTIONS PLAN

The enrollee or applicant may choose the plan (or package) of care options that will be eligible for benefits if they are disabled and eligible for long-term care insurance benefits. Available care options plans are:

a. Facility Plan – Care by a facility only (nursing home or assisted living facility);
b. Facility + Professional Home Care Plan – Care by a facility or professional home care (provided by a licensed home health organization); or
c. Facility + Professional Home Care Plan + Total Home Care Plan – Care by a facility, professional home care, or total home care (provided by anyone including family).

2. MONTHLY BENEFIT AMOUNT

The enrollee or applicant may choose a monthly benefit amount to be paid to them if they are disabled and qualify for long-term care insurance benefits. A monthly benefit amount between $1,000 and $6,000 in $1,000 increments may be elected (elections of $5,000 or $6,000 always require evidence of insurability, as described in O.2). The elected amount is the monthly benefit for nursing home care, which is the highest cost care. If your care is from an assisted living facility, you will receive 60 percent of the monthly benefit amount. If your care is professional home care or total home care, you will receive 50 percent of the monthly benefit amount.

3. DURATION OF COVERAGE

The enrollee or applicant may choose the period of time for which they will receive a long-term care insurance benefit if they are disabled and eligible for long-term care insurance benefits. Three periods of time or durations of coverage are available:

a. Three Years

This provides three years of benefits if paid out at 100 percent for nursing-home care; five years if paid out at 60 percent for assisted-living-facility care; and six years if paid out at 50 percent for professional home care or total home care.

b. Six Years

This provides six years of benefits if paid out at 100 percent for nursing home care; 10 years if paid at 60 percent for assisted-living-facility care; and 12 years if paid out at 50 percent for professional home care or total home care.

c. Unlimited

This provides unlimited benefits regardless of the type of provider (within your elected care option plan) who provides your care and whether the elected monthly benefit amount is paid out at 100 percent, 60 percent, or 50 percent.

4. INFLATION PROTECTION

The enrollee or applicant may choose to purchase inflation protection. This option is designed to inflate your long-term care insurance benefit over time based on the assumption that the cost of long-term care will inflate over time. Inflation protection increases your elected monthly benefit amount by 5 percent each year on a compounded basis up to 200 percent of your original monthly benefit amount.

OTHER PLAN PROVISIONS AND PREMIUM RATES

Carefully read the outline of coverage, rate sheet, and other materials in the long-term care insurance enrollment package before applying for long-term care insurance. The monthly premium is based on the age of the applicant at the time of application and is impacted by each of the above choices. Once enrolled, your monthly premium for the enrolled coverage does not increase with your age (but may be increased by the insurance company).

O.2 EVIDENCE OF INSURABILITY

All eligible employees who apply during their 31-day initial enrollment period are guaranteed coverage for up to $3,000 in a monthly benefit amount and up to a six-year duration of coverage. Employees who apply for more coverage, apply at a later date, and all other eligible applicants must submit evidence of insurability (provide information on their medical status) and may be denied coverage.

O.3 BENEFIT PAYMENT PROVISIONS

You (or a family member enrolled in long-term care insurance) are eligible for a monthly benefit if you meet all of the following conditions:

1. You become disabled.

You are disabled for purposes of long-term care insurance if you meet criteria "a." or "b." below:

   a. You are unable to perform, without substantial assistance from another individual, at least two of the following activities of daily living:
      1) bathing;
      2) dressing;
      3) toileting;
      4) transferring (moving in and out of a bed, chair, or wheelchair);
      5) continence (the ability to maintain control of bowel or bladder function); or
      6) eating.

   b. You require substantial supervision by another individual to protect you from threats of health and safety due to severe cognitive impairment.

2. A physician has certified that you are unable to perform, without substantial assistance from another individual, two or more of the above activities of daily living for a period of at least 90 days, or that you require substantial supervision by another individual to protect you or others from threats to health or safety due to severe cognitive impairment. (A physician's certification is required every 12 months.)

3. You are receiving services in a nursing home or assisted living facility, or you are receiving professional home care (if the care options plan you elected includes a professional home care benefit) or total home care (if the care options plan you elected includes a total home care benefit).

4. You have satisfied the 90-day elimination period specified in your plan. (The elimination period is the number of consecutive days, beginning when you meet the above criteria, that you must wait before receiving benefits.)

Once the above requirements are met, the monthly benefit amount, or the percentages of the monthly benefit amount (specified in O.1 for assisted living facility care, professional home care, and total home care) will be paid to you or your designated guardian regardless of the actual cost of the care.

O.4 COVERAGE CONTINUATION

1. When you stop working for the State of Montana, group long-term care insurance coverage ends, but may be converted to individual coverage at the same premium, as described in F.3. Conversion requests must be submitted to the long-term care insurance company within 31 days of termination of State Plan coverage and premiums must be paid directly to the company.

2. When you are disabled and begin drawing benefits, your coverage will continue at no more cost to you for as long as you continue to be eligible for a monthly benefit. Premiums are not waived while receiving payment for respite care as described in E.4.

P. TERM LIFE INSURANCE

P.1 CORE BENEFITS

The State Plan provides each enrolled employee with some basic term life insurance (Plan A), as part of the core benefits package. This coverage is automatic provided you are eligible and enrolled in the State Plan. See Section B on how to enroll and the current Annual Benefits Summary for the amount of core life insurance.

P.2 LIFE INSURANCE OPTIONS – EMPLOYEE PLANS

Employees may increase their coverage at the favorable rates the State Plan has negotiated with its selected life insurance company as follows:

PLAN C

You may elect optional Plan C coverage of:

1. One times your annual salary rounded to the next highest multiple of $5,000.
2. Additional coverage in $5,000 increments, up to a maximum of $200,000.

Newly eligible employees may receive coverage of one times their annual salary described above without evidence of insurability and approval of the State Plan's life insurance company if they enroll within the 31-day initial enrollment period. Additional coverage and late enrollment requires evidence of insurability and life insurance company approval (see Section B).

If your annual salary increases and exceeds the Plan C coverage based on your earlier annual salary, your Plan C coverage will automatically increase to reflect your new salary. Your premium costs (and payroll deduction) will automatically increase to match the increased coverage. Your premium costs (and payroll deduction) will also automatically increase when your age changes to the next five-year age bracket. See a current rate sheet for premium costs.

COVERAGE CONTINUATION

Coverage will be continued without payment of premium if you qualify for a disability waiver described in E.4 of this document. See Section F for information on conversion to an individual policy when you cease active employment.

P.3 LIFE INSURANCE OPTIONS – DEPENDENT PLANS

Eligible employees may obtain term life insurance coverage on dependents who are eligible for benefits (as defined in A.2) and not specifically excluded below, by electing one or both of the following optional dependent plans (see Section B).

PLAN B – BASIC DEPENDENT LIFE

Plan B provides $2,000 of coverage on your spouse and $1,000 on each child. This coverage is only available during the 31-day initial enrollment period and within 31 days of acquiring a spouse or first child. No evidence of insurability and life insurance company approval is required.

PLAN D – SUPPLEMENTAL SPOUSE LIFE

Plan D provides coverage on your spouse in $5,000 increments of up to 100 percent of your total coverage under Plan C, rounded to the next higher $5,000. The premium for Plan D is based on the employee's age and the premium (and payroll deduction) automatically increases when the employee's age changes to the next five-year age bracket. To receive this coverage you must:

1. be enrolled in Plan C; and
2. submit evidence of insurability for your dependent spouse and be approved by the State Plan's life insurance company.

EXCLUDED DEPENDENTS

The following dependents and former dependents are not eligible for either basic dependent life – Plan B or supplemental spouse life – Plan D:

1. Children or a spouse in full-time active military service.
2. Children age 25 and over, unless the dependent child is disabled under A.3.
3. Married children.
4. A divorced ex-spouse.

COVERAGE CONTINUATION

Dependent coverage will be continued without payment of premiums as follows:

1. For five months after your death.
2. During any period when you become totally and permanently disabled and qualify for continued life insurance and premium waiver as described in E.4.
3. During any period when your only insured dependent is a disabled child as defined in A.3.

See Section F of this document for information on conversion to an individual policy when you cease active employment.

P.4 Beneficiary Designation

When you enroll in core life insurance or optional life insurance benefits, you will be asked to designate one or more beneficiaries. You may designate one or more primary beneficiaries, plus one or more first contingent and second contingent beneficiaries.

At death, benefits will be distributed to a living primary beneficiary or split evenly among multiple living primary beneficiaries, unless you specify their respective shares. In the absence of any living primary beneficiary, benefits will be evenly split among any first contingent beneficiaries, and in their absence, among any living second contingent beneficiaries.

If there are no living designated beneficiaries, benefits will be distributed to the following living relatives in order of distribution: first to the spouse; if the spouse is not living, evenly split among living children; if the children are not living, to surviving parents. If none of these survivors exist, the benefits will be paid to your estate.

When beneficiaries are minor children, benefits are paid to their legal guardian. Trust fund arrangements are available through the life insurance company.

Benefits will not be paid to a beneficiary who intentionally and wrongfully causes an insured's death.

Beneficiary designations may be changed at any time and should be kept current.

P.5 Benefit Payment Provisions

1. DEATH BENEFIT PAYOUT OPTIONS

Death benefits in excess of a threshold amount specified by the life insurance company are paid to beneficiaries though the default mechanism of an interest baring checkbook — unless the beneficiary requests another payout option. A checkbook gives the beneficiary the flexibility of immediately writing a check on (and withdrawing) the entire balance or withdrawing funds at the beneficiary's convenience. Other payout options, which may be requested when a claim is filed, include receiving death benefits in a lump sum or in installments over several years upon mutual agreement between the beneficiary and the State Plan's life insurance company.

2. ACCELERATED BENEFIT OPTION

Employees with life insurance coverage described in this section may receive during their lifetime a portion of their elected life insurance amount as an accelerated benefit if they meet the following eligibility requirements. To apply for this benefit call the Employee Benefits Bureau (EBB).

Eligibility

To qualify, the covered employee must:

a. qualify for waiver of premium (see E.4, provision 1); and
b. give satisfactory proof of having a qualifying medical condition.

A qualifying medical condition means:

1) you are terminally ill, with a life expectancy of less than 12 months; or
2) you are permanently confined to a nursing home and have been in residence there for at least 60 days.

The life insurance company may require a medical exam to verify eligibility.

Benefit

A qualified individual may receive an accelerated benefit of up to 75 percent of their insurance coverage (not including accidental death and dismemberment), not to exceed $150,000. The minimum accelerated benefit is the greater of $5,000 or 10 percent of insurance coverage. If the amount of coverage is scheduled to go down within 24 months of the date you apply for an accelerated

benefit, the benefit will be based on the lesser amount. Benefits are limited to once per lifetime and paid in a lump sum. If you should recover from the qualifying medical condition, you will not be required to repay the benefit.

Exclusions

No accelerated benefit will be paid if:

a. All or part of your insurance must be paid to your child(ren), spouse, or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.

b. You are married and live in a community property state, unless you obtain signed written consent from your spouse.

c. You have filed for bankruptcy, unless you obtain written approval from the bankruptcy court for payment of the accelerated benefit.

d. You are required by a government agency to use the accelerated benefit to apply for, receive, or continue a government benefit or entitlement.

e. You have previously received an accelerated benefit under the group policy.

Q. ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE – PLAN E

Q.1 AD&D Options

Eligible employees may elect accidental death and dismemberment coverage under Plan E on themselves and dependents who are eligible for benefits as follows:

1. ELECTIVE EMPLOYEE AD&D

Up to $200,000 in $25,000 increments, not to exceed 10 times your annualized salary.

2. ELECTIVE DEPENDENT AD&D

If you are enrolled for AD&D on yourself, you may elect the following AD&D coverage on your eligible dependents:

a. on your spouse:
   1) 50 percent of your own coverage, if no children are covered; or
   2) 40 percent of your own coverage, if children are covered.

b. on your child(ren): 10 percent of your own coverage.

Enrollment of eligible employees and dependents does not require evidence of insurability or approval by the State Plan's life insurance company and may be made at any time consistent with mid-year premium change restrictions for individuals under the Premium Payment Plan (see B.5).

Q.2 Benefit Payment Provisions

The amounts listed in the next column are payable for accidental deaths or dismemberments not exempted in Q.3 which:

1. are caused solely and directly by accidental bodily injuries and are independent of all other causes;
2. occur while you are insured under Plan E; and
3. occur within 365 days after the date of the accident.

AMOUNT PAYABLE:

50 percent

Loss of one hand, one foot, or sight of one eye.

100 percent

Any two of the above.

100 percent

Loss of both hands, both feet, or both eyes.

100 percent

Loss of life.

The scheduled benefits will be paid to your designated beneficiary in the event of your accidental death, and will be paid to you in the event of your bodily loss or in the event of your dependent's accidental death or bodily loss.

Q.3 Exemptions

Even though a loss results from accidental bodily injuries, no payment will be made if either the accidental bodily injuries or the loss is caused by or contributed to by any of the following:

1. Insurrection, war, or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict with organized forces of a military nature.
2. Suicide or any other intentionally self-inflicted injury, while sane or insane.
3. Committing or attempting to commit an assault or a felony, or your active participation in a violent disorder or riot. Active participation does not include being at the scene of a violent disorder or riot in the performance of your official duties.
4. The voluntary use or consumption of any poison, chemical compound, or drug (including but not limited to prescribed medications), unless used or consumed in accordance with the directions of a physician.
5. Any sickness or pregnancy existing at the time of the accident.
6. Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction).

7. Medical or surgical treatment for any of 1 – 6 above.

8. Travel, flight, or descent from any kind of aircraft as a pilot or crew member, except in state-owned, leased, or operated aircraft while on state business.

CHAPTER 6
FLEXIBLE SPENDING ACCOUNT BENEFITS

R. FLEXIBLE SPENDING ACCOUNT BENEFITS

See Chapter 1 for information on enrolling in FSAs (B.6), continuing an FSA when you terminate employment, taking a leave of absence, and reinstatement options following a leave or termination. See I.2 for information on submitting claims.

R.1 MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

ELIGIBLE EXPENSES

Out-of-pocket medical expenses, which are eligible for reimbursement from a Medical FSA, include most health care expenses not covered by health insurance or not paid by insurance because of exclusions, limitations, deductibles, and coinsurance requirements. These include out-of-pocket expenses for the following:

Acupuncture

Alcoholism treatment

Ambulance service

Artificial limbs

Birth control pills

Braille books and magazines

Car controls for the handicapped

Chiropractic care

Crutches

Dental fees

Dental implants

Diagnostic tests

Doctors' fees

Duplicate prosthetic devices

Chemical dependency disorders

Drugs requiring a prescription

Experimental medical treatment

Guide dogs

Hearing treatment

Hospital services

Inpatient therapy for mental or nervous disorders

Injections

In-vitro fertilization

Lab fees

Learning disability tuition

Nursing services

Optometrist fees care

Orthodontic treatment that is not primarily cosmetic in nature

Orthopedic shoes

Oxygen

Psychoanalysis

Periodontal services

Laser eye surgery

Special schools for the handicapped

Surgery

Telephone for the deaf

Transplants of organs

Transportation for medical

Vaccinations

Vision exams, including eye glasses and contact lens fees

The list is not complete. More details are available from your current FSA program administrator's web site (see the current Annual Benefits Summary) or IRS Publication 502.

INELIGIBLE EXPENSES

Expenses which are not payable by a Medical Flexible Spending Account include:

1. Any expenses which are not incurred during the benefit year of your FSA.
2. Expenses which are reimbursed by any other source, such as your or your spouse's medical or dental plan or another Flexible Spending Account. (If you receive a duplicate payment, you must declare the second reimbursement as taxable income on your tax return.)
3. Expenses for services or supplies which are cosmetic or not typically medical in nature.

Examples of Ineligible Medical Expenses

Insurance premiums, warranties, service agreements, cosmetic procedures, or products, health club dues, non-prescription drugs, vitamins, and herbs.

ELIGIBLE EXPENSES

The Internal Revenue Service has four basic rules for reimbursement of eligible expenses through a Flexible Spending Account:

1. An individual may only be reimbursed for expenses incurred while a participant in the plan.
2. An expense is incurred when the service is performed, not when it is billed or paid. (If you plan to pay for a service that spans two benefit years through an FSA — such as orthodontia — contact your FSA program administrator in advance of setting up your FSA for best results.)
3. The participant must submit documentation showing when the expense or service was provided. It is very important that the doctor's statement has the type of service provided and the actual dates the service occurred. Payment receipts or bills with "balance forward" amounts will not work.
4. The expense must be reimbursed from FSA funds for the benefit year in which the expense was incurred. Expenses or unused funds cannot be carried over to a different benefit year.

IRS regulations require Medical FSAs to reimburse a claim up to the elected annual amount minus any reimbursements already received, regardless of the account balance at the time the claim is submitted.

R.2 Dependent Care Flexible Spending Account (FSA)

Most expenses for the custodial care of your children or other eligible dependents while you and your spouse work, look for work, or go to school full time are eligible for reimbursement from a Dependent Care FSA.

For Flexible Spending Account purposes the IRS defines eligible dependents as either:

1. Children under age 13 who are claimed by you as dependents on your tax returns.
2. Dependents (like an elderly parent) who are physically or mentally incapable of caring for themselves, live with you, and are being claimed by you as dependents on your tax return.

Services of licensed day-care centers, preschools, caretakers inside your home, and day camps are eligible for Dependent Care FSA reimbursement, provided the expenses are incurred during the benefit year of your Dependent Care FSA.

In order for day care expenses to be eligible, you must report the name, address, and taxpayer identification number of your day care provider on your federal income tax return. Care provided by an individual you claim as a dependent on your tax return (an older brother or sister), child support payments, and overnight camps are not eligible for reimbursement from a Dependent Care FSA. For more information on reimbursable expenses visit your FSA program administrator's web site (listed in the current Annual Benefits Summary), or see IRS Publication 503.

Dependent Care FSAs can only reimburse up to the current account balance at the time a reimbursement claim is submitted. Services must be rendered before reimbursement can be paid.

CHAPTER 7
COORDINATION OF MEDICAL/DENTAL BENEFITS WITH OTHER PARTIES RESPONSIBLE FOR PAYMENT

S. COORDINATION OF BENEFITS

S.1 COORDINATION WITH OTHER MEDICAL & DENTAL BENEFIT PLANS

If a person covered under this State Plan (indemnity medical plan, managed care medical plan, or Dental Plan) is also covered by another plan which provides similar benefits, the medical/dental benefits under this plan and the other plan(s) will be coordinated. This means one plan determines the full benefit it will pay first, then another plan determines the benefits it will pay, but total benefits from all plans will not be more than 100 percent of expenses incurred. Information in S.2 below explains the order in which plans must determine benefits due.

S.2 ORDER OF BENEFIT DETERMINATION

1. ACTIVE EMPLOYEE RULE

The benefits of a plan that covers an individual as an employee will be determined before the benefits of a plan that covers such people as a dependents.

If a state retiree is covered as a dependent under a plan offered to the retiree's spouse as an employee, the benefits of the employed spouse's plan will be determined before the benefits of the state retiree's plan.

2. BIRTHDAY ORDER RULE

The benefits of a plan that covers a dependent of a person whose birthday falls earlier in the year will be determined before the benefits of a plan that covers such people as the dependents of a person whose birthday falls later in the year, except for a dependent child to whom one of the following applies:

a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan that covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.

b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan that covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan that covers that child as a dependent of the stepparent. In addition, the benefits of a plan that covers that child as a dependent of the stepparent will be determined before the benefits of a plan that covers that child as a dependent of the parent without custody.

c. Notwithstanding a. and b. above, if there is a court decree which establishes financial responsibility for the medical, dental, vision, or other health care expenses of the child, the benefits of a plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

3. LONGER COVERAGE RULE

If none of the above rules apply, the plan that has covered the person for a longer period of time will determine its benefits first — with the following exception: the plan that covers the person as an active employee and not a retiree, former employee, inactive employee, or a beneficiary under the Consolidated Omnibus Reconciliation Act of 1986 (or a dependent of that employee or individual), will determine benefits first.

S.3 Coordination with Medicare

If you are eligible for Medicare (currently age 65 or over, or eligible due to disability), how your State Plan coordinates medical benefits with Medicare depends on whether the subscriber is an active employee or retiree. Special rules apply to a member with End Stage Renal Disease (ESRD).

1. ACTIVE EMPLOYEE SUBSCRIBER

Your state medical plan is the primary payer for you and a Medicare eligible spouse. There is little advantage to you or a Medicare eligible spouse to enroll in Medicare Part B until you retire (see E.6, provision 2).

2. RETIREE SUBSCRIBER (INCLUDING A DISABILITY RETIREE)

Your state medical plan is the secondary payer for you and a Medicare eligible spouse for Medicare Part A (hospital benefits) and for Medicare Part B (professional benefits) if you are enrolled in Part B. See E.6, provision 2, for information on how enrolling in Part B affects your state medical plan premium.

When your state medical plan is the secondary payer, benefits otherwise payable to a member under a state medical plan (indemnity medical plan or managed care plan) will be reduced in one of two ways:

a. by limiting the combined payment to 100 percent of allowable charges (so the sum of benefits paid by the State Plan and by Medicare do not exceed the total charge); or
b. by bringing the combined payment up to the benefit payable under your state medical plan, if the Medicare payment is below the benefit payable under your state medical plan.

Before selecting a state medical plan for the coming benefit year, retirees should check the Annual Benefits Summary and other annual change materials to determine how various plans will coordinate with Medicare.

3. PLAN MEMBER WHO IS MEDICARE ELIGIBLE DUE TO END STAGE RENAL DISEASE (ESRD)

For a member who is Medicare eligible due to ESRD, the State Plan is required by federal statue to be the primary payer for a period of time (currently 30 – 33 months, depending on the circumstances). After this period, the State Plan will make secondary payments; Medicare will make primary payments; and you may be eligible for a lower Medicare carve-out premium, provided the member is timely enrolled in Medicare. It is consequently important for a member with ESRD to enroll in Medicare as soon as they are eligible.

S.4 Coordination with Workers' Compensation or Other Governmental Benefits

If expenses for an injury or illness are, should have been, or would be paid for if the member followed applicable rules under any workers' compensation law or other law establishing governmental benefits, expenses arising as a result of the injury or illness shall not be paid under this State Plan, except when required by state or federal law.

S.5 Coordination with a Third Party Who Wrongfully or Negligently Caused Injury to a Plan Member and is Liable For Damages (Subrogation)

If covered expenses payable under the medical and dental chapters of this State Plan (Chapter 3 or a Managed Care Plan Supplement to Chapter 3, and Chapter 4) are the result of injury by a third party, the State Plan shall retain the right of subrogation for those covered expenses paid, pursuant to Section 2-18-901, 902, MCA.

If a State Plan member intends to pursue recovery or institute an action for damages against the party responsible for the injury, the State Plan member shall give the Employee Benefits Bureau (EBB) reasonable notice of the intended recovery or action and notice of any request for shared cost of the recovery or action as provided in 2-18-902(1) and (2), MCA. If the State Plan member elects not to pursue the recovery or institute an action for damages against the party responsible for the injury, the State Plan member shall notify the EBB of this decision and assign their right to such recovery to the State Plan.

If the state elects to participate in the cost of the recovery or action, the state is entitled to recover any benefits paid to the State Plan member from any judgment or recovery received by the member as provided in

2-18-902(4), MCA. If the state elects not to participate in the costs, the state is entitled to recover 50 percent of the benefits paid from any judgment or recovery received by the member as provided in 2-18-902(3), MCA.

The State Plan member shall take no action through settlement or otherwise which prejudices the rights and interests of the State Plan under this provision.

S.6 Right to Information

To determine the applicability of, and implement the terms of this chapter, the claims administrators of state sponsored indemnity or managed care medical plans, or dental plans, may release to, or obtain from, any other insurance company, organization, or person, any information deemed necessary, consistent with provision T.4. This may be done without the consent of or notice to any person. Any person claiming benefits under this Summary Plan Document shall furnish to the applicable claims administration company such information as may be necessary to implement the provisions of this chapter, including but not limited to the necessary written authorization(s) for release of information.

CHAPTER 8
GENERAL PROVISIONS

T. RIGHTS & OBLIGATIONS OF THE STATE PLAN, CONTRACTORS, & MEMBERS

T.1 Plan Amendments

In order to provide the maximum possible benefits within the limits of designated resources and maintain a fiscally sound State Plan, the Employee Benefits Bureau (EBB), in consultation with the State Employee Group Benefits Advisory Council, expressly reserves the right, at any time, and in its sole discretion to:

1. Terminate any medical or dental benefit or amend either the amount or conditions of any medical or dental benefit.
2. Alter the method of payment of any medical or dental benefit.
3. Amend or rescind any other provisions of this Summary Plan Document within limits of any applicable statutes or contractual provisions in effect.
4. Change the required premium or employee contribution.

T.2 Compliance with Law and Regulations

Any provision of this Summary Plan Document, or amendment thereto, which may be in conflict with applicable statutes of Montana or laws and regulations of the United States, is hereby amended to conform with the minimum requirements of those statutes, laws, and regulations.

T.3 Access to Information by Companies and State Administrative Staff Who Administer or Provide State Health Benefits or Services Described in this Document

Claims administrators, managed care companies, and other contractors involved in providing or administering health benefits for the State Plan shall have access to medical, hospital, and dental records relating to the diagnosis, treatment, or services provided to the member or to other information needed to administer provisions of this Summary Plan Document and any applicable Managed Care Plan Supplement hereto. Providing such access is a condition of receipt of medical and dental benefits under the State Plan and benefits may be denied if access to required information is denied. Such information will be protected as specified in T.4.

Insurance companies who provide other state-sponsored insurance benefits (such as long-term care, life, and accidental death and dismemberment insurance, etc.) shall have access to information required to verify a loss or administer provisions of the insurance policy. Providing such access is a condition of receipt of benefits.

State administrative staff members directly involved in:

a. conducting claim reviews requested by State Plan members;
b. reviewing requests by members, or the State Plan's managed care company, for extended case management services;
c. reviewing requests for alternate benefits; and
d. reviewing eligibility for State Plan membership

shall have access to the information needed to conduct these activities and shall keep it strictly confidential as specified in T.4.

T.4 Compliance with Privacy Regulations and Other Requirements of the Health Insurance Portability and Accountability Act (HIPAA)

The State Employee Benefit Plan will protect the privacy of its member's Protected Health Information (PHI) by complying with the requirements of HIPPA including:

1. Incorporating HIPAA privacy requirements into contracts with all companies or organizations which have contracts with the EBB to administer or provide state health benefits or services and consequently have access to PHI. (All contracts currently have privacy requirements, but some may need to be revised to conform to HIPPA requirements.)
2. Restricting the use and disclosure of PHI by contractors and state employee benefits and operations staff to the minimum amount necessary to fulfill their specific purpose, including:
   a. treatment, including the provision coordination and management of health care;
   b. payment, including the payment of premiums, contributions, benefits, and cost-sharing amounts; coordination of benefits; subrogation; and activities related to reimbursement through insurance; and
   c. health care operations, including quality assessments, certain health improvement activities, underwriting or premium rating, performance or arrangement of audits and legal services, creation and provision of aggregate data for analysis, resolution of grievances, and due diligence in corporate transactions.
3. Providing members with access to any of their PHI held by contractors of the EBB.

T.5 Right to Conduct a Medical Examination or Autopsy

The State Plan, at its own expense, shall have the right and opportunity to require an examination by an independent medical professional of any member. The plan also has the right to order an autopsy, where it is not forbidden by law.

T.6 Right to Make Payments

Managed care companies offering state sponsored managed care benefit plans, and the claims administration company which administers state indemnity medical plans may, at the state's discretion, make payment to the member, the provider, the member and the provider jointly, or any person, firm, or corporation who paid for the services on the member's behalf.

Whenever payments that should have been made under a state sponsored medical or dental plan have been made by any other plan or governmental program, the managed care company (if a managed care plan) or the claims administration company (if a dental or indemnity medical plan) shall have the right, exercisable alone and in its sole discretion, to reimburse the organization making such other payments in any amounts that are determined to be warranted in order to satisfy the provisions of this Summary Plan Document and any applicable Managed Care Plan Supplement. These amounts are benefits paid under the State Plan, and to the extent of such payments, the managed care plan, claims administration company, and State of Montana shall be fully discharged from liability under this State Plan.

T.7 Right to Recover Payments

Whenever payments have been made in excess of the amount of payment necessary to satisfy the intent of the provisions of this Summary Plan Document, a managed care company which administers a state sponsored managed care plan or the claims administration company which administer the dental and indemnity medical plans shall have the right to recover the excess payment from any one or more of the following:

1. Any person such payments were made to, for, or on behalf of.
2. Any other insurance company.
3. Any other organizations.

T.8 No Obligation to Provide Benefits if Medical and Dental Care is Not Available

Neither the State, the State Plan, or any insurance plan contracting with the State Plan is obligated to provide benefits if hospital facilities are not available, or if care is not available because of epidemic, public disaster, or other causes beyond its control.

T.9 State Not Liable for Acts of Medical/Dental Care Providers

The State will not be liable for any act of commission or omission by any hospital, medical, or dental care provider.

T.10 Coverage Extends to Services Outside the United States

Expenses for services provided outside the United States are covered in the same manner as expenses for services provided within the United States.

T.11 Clerical and Plan Representation Errors

Clerical errors or misrepresentations shall not prevent administration of the State of Montana Employee Benefit Plan in strict accordance with its terms. Authority to interpret the provisions of this plan is vested solely in the Department of Administration, EBB, acting through its duly authorized employees, except as specifically delegated to companies providing contractual services, acting through their respective staff members dedicated to service of the State Plan.

T.12 Alternate Benefit

The State Plan may, at its sole discretion, make payment for medical or dental services that are not listed as covered services or benefits of this Summary Plan Document in order to provide quality care at a lesser cost. Such payments shall be made only upon mutual agreement by the member, subscriber (if other than the member), and the State Plan.

T.13 Members May be Removed From State Employee Benefit Insurance Plans for False Claims

Any State Employee Benefit Plan member or provider who submits bad faith or false claims, misrepresents facts, or attempts to perpetuate a fraud upon a state employee benefit insurance plan may be subject to criminal charges or a civil action brought by the plan administrator or the EBB as permitted under state and federal laws. Additionally, if a member has been found to have committed such acts after an informal, non-MAPA hearing with the plan administrator or EBB, they shall immediately become ineligible to remain on the plan.

T.14 Members May be Removed From State Employee Benefit Insurance Plans for a Pattern of Frivolous Claim Appeals

A State Employee Benefit Plan member who evidences a pattern of appealing baseless, frivolous claims that were initially denied, may be dropped from the plan. The plan administrator or EBB shall issue a 15-day notice to the plan member to cease and desist and abide by the plan terms or be dropped. If the member continues to insist on appealing matters that are deemed frivolous, the plan administrator or EBB may issue a 30-day notice dropping the member from the plan.

CHAPTER 9
DEFINITIONS

ACCELERATED BENEFIT (APPLIES TO LIFE INSURANCE ONLY)

A partial life insurance benefit that a subscriber may receive during the subscriber's lifetime if the subscriber qualifies for a waiver of life insurance premium (described in E.4 of this document) and meets the eligibility requirements of terminal illness or confinement to a nursing home (described in P.5).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D) AND AD&D INSURANCE COMPANY

Insurance which pays a specified percentage of the amount of AD&D coverage, for which you enrolled, in the event of accidental loss of your (or a covered dependent's) life, one or more specified body parts, or eye sight. Accidental death and dismemberment insurance company refers to the company on contract with the Employee Benefits Bureau (EBB) to offer AD&D insurance plan options to State Plan subscribers. See Section Q and the current Annual Benefits Summary for information on the program and the current AD&D insurance company.

ALLOWABLE CHARGE(S)

Charges, which are both:

1. for services covered by the state's medical plan, in which you are enrolled, and
2. within an applicable negotiated fee contained in a State Plan contract with the provider, or in the absence of such a contract, within the allowable fee established by the plan (if a managed care plan) or by the State Plan's claims administration company (if an indemnity medical plan).

ALLOWABLE FEE

a. For Indemnity Medical Plans and the Dental Plan

The dollar allowance for each procedure set by the State Plan's claims administration company based on the following:

1) Any applicable contractual fee agreement between the claims administration company and provider.
2) The Resource Based Relative Value System (RBRVS) developed by the Harvard School of Public Health Study for the Centers for Medicare and Medicaid Services (formerly HCFA) used to assign values to procedure codes based on resources related to the procedure (such as the time required by the provider, intensity of work effort, practice costs, and malpractice insurance costs). This value is multiplied by a conversion factor to arrive at a dollar allowance. The conversion factor is based on the level of practice (physician, mid-level nurse practitioner, etc.), current charges by Montana providers, Medicare's conversion factor, the consumer price index, and the cost impact.
3) In the absence of the above, a percentile of actual charges by like providers in the geographical area.

The allowance for non-participating professional providers in Montana is set 10 percent below the allowance for participating providers defined in this chapter.

b. For Managed Care Benefit Plans

The allowance for each procedure set by the managed care plan based on:

1) any applicable contractual fee agreement between the managed care plan and the provider; and
2) the managed care plan's selected methodology for assigning allowances to procedure codes.

c. For the State Plan's Prescription Drug and Vision Exam Insurance Plans

The fee allowance for each prescription drug (set by the prescription benefits management company) and vision exam service (set by the vision insurance company) based on their:

1) contractual agreement with the EBB; and
2) any applicable fee agreements with manufacturers and retailers.

ANNUAL BENEFITS SUMMARY

A summary of current benefits under state sponsored employee benefit plans (medical, dental, life, etc.) for the specified benefit year. The Annual Benefits Summary includes information on current deductibles, copayments, coinsurance, benefit maximums, preferred providers offering enhanced benefits, and how to contact companies administering the various benefit plans. A current Annual Benefits Summary is distributed each annual change period for the coming benefit year, and may be obtained from the EBB.

ANNUAL CHANGE PERIOD

A period of time, designated by the EBB, in which State Plan subscribers may change their medical plan and make allowed changes in optional benefits for the coming benefit year.

ASSISTED LIVING FACILITY (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

A 24-hour residential facility that provides assistance to the elderly and/or people with disabilities. An assisted living facility may also be referred to as a residential care facility or as an adult foster care facility.

BENEFIT YEAR

The period commencing January 1 and ending December 31 of each year.

CARE OPTIONS PLAN (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Any one of three care option packages that you (or a family member) must elect when enrolling in long-term care insurance, described in R.. The care option plan determines the type of long-term care (nursing home care, assisted living facility care, professional home care, or total home care) that is eligible for benefits if you (or a family member) are disabled and qualify for benefits.

CARE MANAGEMENT

A program administered by the managed care company under contract with the EBB to assess and evaluate options and services required to meet the health care needs of indemnity medical plan members, promote quality cost-effective care, and maximize benefits. This can involve a team of health care providers in addition to the member and member's physician or other provider. See L.39 for a complete description of the program.

CERTIFICATION (OF MEDICAL NECESSITY) AND PRE-CERTIFICATION

Certification is a determination by a managed care plan (for members on a managed care benefit plan) or the State Plan's managed care company (for members on an indemnity plan) that a hospital inpatient stay meets medical necessity criteria for inpatient benefits. Additionally, in the case of a managed care benefit plan, a determination that the inpatient hospital stay also meets (or fails to meet) the criteria for the in-network level of benefits. Pre-certification is certification in advance of a non-emergency admission.

CHEMICAL DEPENDENCY

Substance abuse and addiction, including alcoholism and drug addiction, involving such substances as ethyl alcohol, tranquilizers, narcotics, narcotic synthetics, sedatives/hypnotics, amphetamines, cocaine, hallucinogens, products containing tetra-hydro-cannabinol, and volatile inhalants.

CHEMICAL DEPENDENCY TREATMENT FACILITY

A facility that provides a program for the treatment of chemical dependency in accordance with a written treatment plan approved and monitored by a physician or addiction counselor certified by the state. The facility must also be approved as a chemical dependency treatment facility by the Montana Department of Public Health and Human Services.

CLAIMS ADMINISTRATION AND CLAIMS ADMINISTRATION COMPANY

The function and management of determining and making appropriate payment of claims under the terms of an insurance benefit plan. Claims administration company refers to the company under contract with the EBB to provide claims administration services for its indemnity medical plans and Dental Plan. See the current Annual Benefits Summary for information on the current claims administration company.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 and subsequent amendments (Public Law 99-272, Title X), which entitles a member of a group medical plan who loses eligibility for group benefits to extend coverage for a specified period of time by self-

paying premiums. The term COBRA is used to refer both to the law and to the coverage extension program required by the law (see E.2).

COINSURANCE

Coinsurance is a means of cost sharing. The State Plan pays a percentage of allowed charges (after any applicable deductible has been met) and the member pays a percentage — the coinsurance. See the current Annual Benefits Summary for your current coinsurance for various services. Coinsurance is the cost sharing method typically used for an indemnity medical plan.

CONTINGENT STEP THERAPY

Trial of a lower-cost prescription drug option for treatment of an illness or injury before moving to a high-cost designer drug.

COPAYMENT

Copayment like coinsurance, is also a means of cost sharing. After any applicable deductible has been met, you pay a fixed dollar amount, the copayment, for a covered service and the State Plan pays remaining allowable charges. See the current Annual Benefits Summary for any current copayment obligations. Copayment is the cost sharing method typically used for a managed care benefit plan.

CORE BENEFITS

The minimum benefits package an active employee or non-Medicare retiree enrolled in the State Plan may carry. Core benefits are:

1. Medical insurance (you choose one of the available medical plans);
2. Dental insurance; and
3. Basic (Plan A) life insurance.

COVERED DENTAL SERVICE

A service, procedure, or supply that is:

1. listed in Section N of this Summary Plan Document and not excluded in N.7;
2. provided to a member by a covered provider; and
3. provided and coded in accordance with applicable dental policy.

COVERED MEDICAL EXPENSE (AND COVERED DENTAL EXPENSE)

An expense within allowable charges and any specified benefit limitations for a covered medical service (or a covered dental service) defined above.

COVERED MEDICAL SERVICE

A service, procedure, or supply that meets the following criteria:

1. Listed as a benefit in Section L and not excluded in Section M of this document. For a managed care benefit plan, covered medical service is a benefit listed in the plan's Managed Care Plan Supplement to this Summary Plan Document — and not excluded in the supplement.
2. Determined to be medically necessary for the diagnosis or treatment of injury, illness, or maternity care (unless a preventive benefit clearly listed in this document or an applicable supplement for a managed care benefit plan). (Expenses associated with inpatient hospital days only meet medical necessity criteria for an indemnity medical plan if they are certified as described in L.2.)
3. Provided to a member by a covered provider.
4. Provided and coded in accordance with applicable medical policy, as defined in this chapter.

COVERED PROVIDER

A provider of medical and/or dental services, who has both:

1. satisfied the necessary requirements to practice within the State of Montana or in another state or country where services are received; and
2. been recognized by the company which administers claims for the Dental Plan and your selected medical plan as a provider of the kind of services received, based on the nature of the services and extent of the providers licensure.

A provider may, because of the limited scope of practice, be a covered provider only for certain services.

CREDITABLE COVERAGE

Previous comprehensive medical and dental coverage of a new State Plan enrollee under any of the following plans and programs, provided there is no 63-day or greater lapse in coverage:

1. Group health plan.
2. Individual health and/or dental plan.
3. Medicare.
4. Indian Health Services coverage.
5. State health risk pool.

6. Public health plan.
7. Other coverage as specified by the Health Reform Act of 1996.

There must not be a lapse of 63 days or more between the previous coverage and enrollment in the State Plan. If there was an earlier 63-day or greater lapse in the prior coverage, only prior coverage since the lapse is creditable coverage.

CUSTODIAL CARE

The provision of room and board, with or without routine nursing care, training, personal hygiene, and other forms of self care or supervisory care for a person who is mentally or physically disabled as a result of retarded development or body infirmity, and who is not under special medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable such person to live outside an institution. Custodial care includes services or treatment that could be rendered safely by a person without medical skills and is mainly to help the patient with daily living activities.

DEDUCTIBLE

Allowed charges a member and family must pay before a medical plan makes payment.

DENTAL PLAN

A plan of dental benefits offered by the State Plan to its subscribers that primarily pays an allowed fee (less any member deductible and coinsurance obligation) for covered dental services defined in Chapter 4.

DEPENDENT (OR ELIGIBLE DEPENDENT)

An individual who has a relationship to a State Plan subscriber, as described in A.2 of this document, which makes the individual eligible to be enrolled in the State Plan when the individual meets other enrollment requirements described in Chapter 1.

DURABLE MEDICAL EQUIPMENT

The least expensive appropriate equipment for medically necessary therapy of a medical condition in your home. Covered durable medical equipment must meet the following criteria:

1. Able to withstand repeated use — consumable goods are not covered.
2. Generally not useful to a person who is not ill or injured.
3. Primarily used to serve a medical purpose rather than comfort and convenience.
4. Prescribed by a physician.

The following are examples of items that are not covered as durable medical equipment:

1. Exercise equipment.
2. Car lifts or stair lifts.
3. Biofeedback equipment.
4. Self-help devices which are not medical in nature, regardless of the relief they may provide for a medical condition.
5. Air conditioners and purifiers.
6. Whirlpool baths, hot tubs, or saunas.
7. Water beds.
8. Computerized and deluxe equipment like motor-driven wheelchairs or beds when standard equipment is adequate.
9. Other equipment which is not always used for healing or curing.

DURATION OF CARE (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Any one of three periods of time you (a family member) must elect when enrolling in long-term care insurance, described in R.1. The duration of care determines the maximum duration of benefits if you (or a family member) become disabled, qualify for benefits, and receive care by a nursing home. The duration is extended if care is provided by a covered provider other than a nursing home, as described in R.1, provision 3.

EFFECTIVE DATE

The date on which a new enrollee's coverage begins.

EMERGENCY MEDICAL CONDITION

A condition manifesting itself with symptoms of sufficient severity, including severe pain, and which the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. The member's health would be in serious jeopardy.
2. The member's bodily functions would be seriously impaired.

3. A bodily organ or part would be seriously damaged.

EMPLOYEE BENEFITS BUREAU (EBB)

The bureau within the state Personnel Division of the Department of Administration, which administers the State Employee Benefit Plan. The EBB can be reached at 444-7462 in Helena; 1-800-287-8266 outside of Helena; or you may find information you need at its web site (www.discoveringmontana.com/doa/spd/css/benefits/healthbenefits.asp).

EMPLOYEE OR ELIGIBLE EMPLOYEE

An individual who is employed by the State of Montana and who is eligible to be enrolled in the State Employee Benefit Plan as defined in Chapter 1 of this document.

EMPLOYEE ASSISTANCE PROGRAM (EAP) AND EMPLOYEE ASSISTANCE PROGRAM ADMINISTRATOR

A program providing confidential, short-term counseling services to subscribers and family members (whether or not the family member is enrolled in the State Plan), and administered by an Employee Assistance Program administrator on contract with the EBB. See Section M of this Summary Plan Document and the current Annual Benefits Summary for additional information.

ENROLL, ENROLLED

An eligible individual's act of completing necessary requirements and procedures to obtain coverage or membership; a plan's or program's act of extending coverage or membership; and the past extension of coverage or membership which is still in effect in any plan or program to which the term is applied.

EVIDENCE OF INSURABILITY

An application to an insurance plan for coverage involving submission of medical information and documentation required by the plan to determine if the applicant meets plan requirements for enrollment.

EXPERIMENTAL PROCEDURES OR SERVICES

Treatment, which is considered experimental because it meets one of the following criteria:

1. Prescription drugs not approved by the FDA to be lawfully marketed for the proposed use, and it is not identified in the American Hospital Formulary Service, the AMA Drug Evaluation, or the Pharmacopoeia as an appropriate use.
2. It is subject to review or approval by an institutional review board (meaning that a hospital considered it experimental and put it under review to meet federal regulations, or review is required and defined by federal regulations, particularly those of the FDA or Department of Health and Human Services).
3. It is the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in FDA regulations, regardless of whether it's an FDA trial.
4. It has not been demonstrated through prevailing, peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
5. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, and effectiveness (or effectiveness compared with conventional alternatives), and/or that usage should be substantially confined to research settings.
6. It is not a covered benefit under Medicare as determined by the Centers for Medicare and Medicaid Services (CMMS, formerly HCFA) because it is considered experimental, investigational, or unproven.
7. It is experimental, investigational, unproven, or not a generally acceptable medical practice in the predominate opinion of independent experts utilized by the administrator of each plan.
8. It is not experimental or investigational in itself pursuant to the above and would not be medically necessary, but it is being provided in conjunction with the provision of a treatment, procedure, device, or drug which is experimental, investigational, or unproven.

FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

A program under which enrolled employees pay for eligible expenses on a pre-tax basis and save tax dollars. It is offered in accordance with U.S. Internal Revenue Code (IRC) Section 125 and applicable regulations. A

Medical FSA allows you to pay for your own or a family member's eligible medical expenses, which are not covered by insurance (including expenses that you must pay to meet deductible, coinsurance, or copayment requirements), on a pre-tax basis. A Dependent Care FSA allows you to pay for eligible day care expenses for dependents on a pre-tax basis. See B.6 and Chapter 6 for details of this program.

FLEXIBLE SPENDING ACCOUNT PROGRAM ADMINISTRATOR

The company under contract with the EBB to administer the Flexible Spending Account Program. See the current Annual Benefits Summary for information on the current Flexible Spending Account program administrator.

FOCUSED CASE AND DISEASE MANAGEMENT

Care management services to members identified as having significant medical risks, chronic health care needs, or a catastrophic accident or illness which can benefit from focused services of a care management nurse. This nurse works with the member, attending physician, and family to identify and arrange the most appropriate, effective, and cost-efficient treatment or disease management program possible and make the best use of available insurance benefits.

FORMULARY

A listing of brand name prescriptions which are preferred prescriptions in their therapeutic class because of their effectiveness and favorable cost, including favorable manufacturer rebates. Copayments and/or coinsurance amounts members pay for formulary prescriptions are lower than for non-formulary brand name prescriptions.

HOME HEALTH AGENCY

An agency licensed by the state which provides part-time skilled nursing services and other covered therapeutic services including physical, speech, and occupational therapy, medical social services, and home health aide services.

HOME INFUSION THERAPY

The preparation, administration, or furnishing of parenteral medications, or parenteral or enternal nutritional services to a member by a home infusion therapy agency. Services include education for the member, the member's care giver, or a family member.

HOME INFUSION THERAPY AGENCY

A health care facility that provides home infusion therapy services. A licensed hospital that provides home infusion therapy services must have a home infusion therapy agency license or endorsement.

HOME HEALTH CARE PLAN

A written treatment plan established by a physician who certifies that the home health care plan is medically necessary.

HOSPICE

A facility, agency, or service that meets the following criteria:

1. Arranges, coordinates, and/or provides care for the terminally ill patient.
2. Is licensed, accredited, or approved by the state to establish and manage hospice care programs.
3. Maintains records of hospice care services provided and bills for such services.
4. Is a home health agency, which provides hospice care.

HOSPITAL

An acute-care facility licensed by the state where it is located and which meets the following criteria:

1. Primarily provides facilities for diagnosis and therapy for medical/surgical treatment under the supervision of a staff of physicians.
2. Provides 24-hour daily nursing services under the supervision of registered graduate nurses.

The term does not include the following, even if such facilities are associated with a hospital:

a. a nursing or convalescent home.
b. a rest home.
c. hospice.
d. a rehabilitation facility.
e. a skilled nursing facility.
f. a place for care and treatment of chemical dependency.
g. a place for the treatment of mental illness.
h. a long-term chronic-care institution or facility providing the type of care listed above.

The term hospital for purposes of certification includes any facility that provides inpatient medical, psychiatric, or chemical dependency services, not just facilities that meet the above definition.

IDENTIFICATION CARD (IDENTIFICATION NUMBER)

The card you receive from the company that provides claims administration for your selected state sponsored medical plan, your Dental Plan (if a different claims administrator), and your Prescription Drug Plan. An identification card provides such information as a unique subscriber identification number, a group identification number, and other information required for claims administration. It may also include information on dependent coverage, plan requirements, and customer service.

INCLUSIVE SERVICES/PROCEDURES

A portion of a service or procedure that is necessary for completion of the service or procedure, or which is considered to be part of another service or procedure.

INDEMNITY MEDICAL PLAN

A plan of medical benefits offered by the State Plan to its subscribers that primarily pays an allowed fee (less any member deductible and coinsurance obligation) for medically necessary covered medical services of any covered provider (including participating and non-participating providers). Plans currently called "traditional" and "basic" are indemnity medical plans. An indemnity medical plan may include some medical managed care and some preferred providers whose fees are paid at a higher percentage by the plan in exchange for contractual limitations on the fees. However, most benefits are not determined by whether services are received in-network or out-of-network, as is typical of a managed care benefit plan.

INITIAL ENROLLMENT PERIOD

The first 31 days following the date an employee first becomes eligible to enroll in the State Employee Benefit Plan. For new employees, this is the 31 days following the first day of employment.

IN-NETWORK LEVEL OF BENEFITS

The highest level of benefits provided by a managed care benefit plan, as defined in the current Annual Benefits Summary. The member meets the requirements for these benefits as specified in the applicable Managed Care Plan Supplement to this document.

IN-NETWORK (NETWORK) PROVIDER

A covered health care provider who has (or group of providers who have) contractually agreed to provide medical services to members of a managed care plan according to the fees and other terms of a managed care plan contract. Benefits for services provided in-network (by an in-network provider) are typically higher level benefits (the in-network level of benefits) than benefits for services out-of-network (by another provider) — unless there is a required referral. For referral requirements of a managed care benefit plan, see the applicable Managed Care Plan Supplement for Chapter 2. Please note that participating providers defined below are not in-network providers.

LEGEND DRUG

Any drug product which bears the legend "Caution: Federal law prohibits dispensing without a prescription."

LIFE INSURANCE AND LIFE INSURANCE COMPANY

Term life insurance that pays to designated beneficiaries the amount of insurance you enrolled (or you enrolled a dependent) for under the terms of the insurance policy if you (or your dependent) die and are still covered at the time of death. Life insurance company refers to the company on contract with the EBB to offer life insurance plans to State Plan subscribers. Term life insurance pays only in the event of death, and has no redeemable cash value. See Section P of this document for details. A copy of the controlling policy or certificate of coverage is available upon request.

LONG-TERM CARE (LTC) INSURANCE AND LONG-TERM CARE INSURANCE COMPANY

Insurance that pays your (or an enrolled family member's) elected monthly benefit amount (or a defined portion of that amount for other than nursing home care), if you are (or a covered family member is) disabled under the terms of the policy, enrolled at the time of disability, and receive care from a provider that is covered under the elected plan of care. Long-term care insurance company refers to the company on contract with the EBB to offer long-term care insurance plans to State Plan subscribers and eligible family members. See Section R of this document and a long-

term care insurance enrollment kit for details. A copy of the controlling policy or certificate of coverage is available upon request.

MANAGED CARE COMPANY

The managed care company under contract with the EBB to provide care management services for state sponsored indemnity medical plans by assessing and evaluating options and services required to meet the health care needs of indemnity medical plan members and promoting quality, cost-effective care.

MANAGED CARE BENEFIT PLAN

A plan of medical benefits and the requirements, arrangements, and conditions for receipt of benefits described in a Managed Care Plan Supplement to this Summary Plan Document (as well as applicable provisions of this document and annual benefit summaries). A managed care benefit plan is administered by a managed care plan (defined below) and includes both higher level benefits (the in-network level of benefits) when medical services are received in-network or with a required referral, and lower level out-of network benefits for most services when they are received from an out-of-network provider without a required referral.

MANAGED CARE PLAN

A Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or other organization which is licensed in the State of Montana to provide managed health care benefits primarily through its in-network providers, and which is on contract with the EBB to provide or administer a managed care benefit plan for State Plan subscribers (and their dependents) who select them.

MANAGED CARE PLAN SUPPLEMENT TO THE SUMMARY PLAN DOCUMENT

A supplement to this document for each managed care plan, specifying applicable managed care benefit plan provisions administered by that managed care plan.

MAXIMUM LIFETIME BENEFIT

The maximum benefit a medical plan pays to any one member per lifetime. For indemnity medical plans, a small benefit is restored after the maximum lifetime benefit has been met as described in L.1, provision 3, of this document. See the current Annual Benefits Summary for the maximum lifetime benefit in effect for each medical plan.

MEDICAL NECESSITY (MEDICALLY NECESSARY)

A service or supply provided by a covered provider of your selected medical plan and determined by the company which provides claims administration services for the plan to meet the following criteria:

1. Appropriate for the symptoms and diagnosis of the member's condition, illness, or injury.
2. Provided for the diagnosis, or the direct care and treatment of the member's condition, illness, or injury.
3. In accordance with standards of benefit year practice.
4. Not primarily for the convenience of the member or the provider.
5. The most appropriate supply or level of service that can safely be provided to the member. When applied to inpatient care, this further means that the member requires acute care as a bed patient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care on an outpatient basis.

The fact that services were recommended or performed by a covered provider does not automatically make the services medically necessary and a service may meet medical necessity criteria but not be a covered benefit of the plan. To determine if a planned procedure or service meets medical necessity criteria and is a covered benefit of the plan you may obtain a prior authorization described in G.5 if you are on an indemnity medical plan. If with a managed care medical plan, you may contact the customer service department of the plan for assistance.

MEDICAL POLICY (AND DENTAL POLICY)

The policy applied by the company which administers claims for a health plan (or dental plan) to determine if health (or dental) care services — including procedures, medication, equipment, processes, and technology — meet nationally accepted criteria such the following:

1. Final approval from the appropriate governmental regulatory agency or agencies.
2. Conclusive scientific evidence of improved health outcome.

3. Compliance with established standards of good medical (and dental) practice and established coding procedures for insurance reimbursement.

MEMBER

An enrolled employee, former employee who has continued State Plan coverage under the provisions of Section E, or enrolled dependent who remains eligible and covered by the State Plan and any insurance plan or program offered by the State Plan to which the term member is applied.

MENTAL HEALTH TREATMENT FACILITY

A facility which provides treatment for mental illness through multiple modalities or techniques following a written treatment plan approved and monitored by an interdisciplinary team including a licensed physician, psychiatric social worker, and psychologist. The facility must also be:

1. licensed as a mental health treatment facility by the state,
2. funded or eligible for funding under federal or state law, and
3. affiliated with a hospital with an established system for patient referral.

MENTAL ILLNESS

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with any of the following:

1. Present distress or a painful symptom.
2. A disability or impairment in one or more areas of functioning.
3. A significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Mental illness does not include:

1. Developmental disorders.
2. Speech disorders.
3. Psychoactive substance abuse disorders.
4. Eating disorders (except bulimia and anorexia nervosa).
5. Impulse control disorders (except for intermittent explosive disorder and trichotillomania).
6. Severe mental illness (defined below).

MID-LEVEL PRACTITIONER

A licensed APRN (Nurse Practitioner), PA (Physician Assistant), or CNMW (Certified Nurse Midwife) who practices in conjunction with a licensed M.D. or O.D. This practice must include 24-hour coverage for emergency admissions and health care.

MONTHLY BENEFIT AMOUNT (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Any one of six monthly benefit amounts you (or a family member) must elect (when enrolling in long-term care insurance benefits) to receive if you (or a family member) become disabled, qualify for benefits, and receive care from a nursing home. This amount increases each year if inflation protection described in R.1 was elected, and a designated portion of the elected amount (as increased by applicable inflation protection) is the benefit for care from a covered source other than a nursing home.

MORBID OBESITY

A condition of persistent and uncontrollable weight gain that is potentially life-threatening and is defined as a body mass index (BMI) greater than 40. BMI is calculated as weight (kilograms)/height (meters) squared.

OBSERVATION BEDS/ROOMS

Outpatient beds that are used to either:

1. provide active short-term medical/surgical nursing services, or
2. monitor the stabilization of the patient's condition.

OCCUPATIONAL THERAPY

Treatment of the physically disabled due to disease, injury, or loss of bodily part by means of constructive activities designed and adapted to promote the restoration of an individual's ability to perform required daily living tasks.

OPTIONAL BENEFITS

Benefits sponsored by the State Plan in which employee subscribers, and in some cases other State Plan members, may choose to enroll, or if required apply for coverage on themselves and eligible dependents. Optional benefits include dependent medical and dental insurance benefits, life insurance plans B, C, and D, accidental death and dismemberment Plan E, long-term care insurance, and Flexible Spending Accounts. For information on optional benefits, see this Summary Plan

Document. A copy of the controlling policies or certificates of coverage are available upon request.

OUT-OF-NETWORK LEVEL OF BENEFITS

The lower level of benefits provided by a managed care benefit plan (as defined in the current Annual Benefits Summary), when the member uses a provider outside the HMO provider network without a required referral. (Required referrals are specified in the applicable Managed Care Plan Supplement to this document.)

OUT-OF-NETWORK PROVIDER

Any covered provider who is not an in-network provider of a managed care plan, as defined above. Out-of-network providers include participating providers who are participating only to the extent that they accept a managed care plan's allowable fees, but who have not agreed to other terms of a managed care network contract.

OUT-OF-POCKET MAXIMUM

The maximum amount of any coinsurance and copayments, which are credited toward an insurance plan's out-of-pocket maximum, that you must pay in a benefit year for:

1. an individual member (the individual out-of-pocket maximum), or
2. enrolled family members (the family out-of-pocket maximum).

Once a member meets the plan's individual out-of-pocket maximum, no more coinsurance or copayments, which are credited toward the out-of-pocket maximum, must be made for that member for the remainder of the benefit year. Once an enrolled family has met the plan's family out-of-pocket maximum, no more coinsurance or copayments, which are credited toward the out-of-pocket maximum, must be made for any enrolled family member for the remainder of the benefit year. See the Annual Benefits Summary for the current benefit year for information on the individual and family out-of-pocket maximums and the coinsurance and copayments that are credited to the out-of-pocket maximum.

Related Information

There are separate out-of-pocket maximums for your medical plan and the Prescription Drug Plan. There is no out-of-pocket maximum for the Vision Insurance Plan.

PARTIAL HOSPITALIZATION (FOR MENTAL ILLNESS ONLY)

A time-limited ambulatory (outpatient) program offering active, therapeutically intensive treatment, which involves structured clinical services within a stable, therapeutic program. The program can involve day, evening, and weekend treatment. The underlying aim of this treatment is clinical stabilization required due to severe impairment and/or dysfunction in major life areas. A partial hospitalization program should offer four – eight hours of therapy five days a week. The hours of therapy per day and the frequency of visits per week will vary depending on the clinical symptoms and progress being made with each individual.

PARTICIPATING PROVIDER (PARTICIPATING PHARMACY)

A provider who has agreed to accept allowable charges as payment in full and not bill State Plan members extra amounts. Lists of participating providers for the medical and dental plans, as well as participating pharmacy providers for the Prescription Drug Plan, are available at the web site (www.discoveringmontana.com/doa/spd/css/benefits/healthbenefits.asp), which provides links to the participating provider lists for each plan, or by calling the customer service number on the identification card for the plan. A managed care plan may have a broad network of providers who are participating only to the extent that they accept a plan's allowable fees, as well as a smaller group of in-network providers (defined above) who have agreed to provide services for a lower fee under the terms of a managed care plan contract.

PERSONAL CARE PROVIDER (PCP)

A physician or mid-level practitioner, who specializes in family practice, internal medicine, general practice, or pediatrics, and who is selected by a member to manage their continuum of care and coordination of covered services. Alternatively, a member may select an in-network OB/GYN as the PCP if that physician has agreed to be a personal care provider.

PHYSICAL THERAPY

Treatment of disease or injury by physical means such as hydrotherapy; heat or similar modalities; physical agents; bio-mechanical and neuro-physiological principles; and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a body part.

PHYSICIAN

An individual who has satisfied the necessary qualifications to practice as an M.D. (Doctor of Medicine) or O.D. (Doctor of Osteopathy).

POINT-OF-SERVICE PLAN

A point-of-service plan is a medical plan in which the level of benefits you receive for a medical service is determined by the health care provider you use for the service. If you use an in-network provider, you receive higher level (in-network) benefits. If you use a provider outside the Plan's network without a required referral, you receive lower level (out-of network) benefits with a separate deductible and out-of-pocket maximum. State sponsored managed care benefit plans are point-of-service plans for most services.

PREFERRED PROVIDER

A health care provider who has contractually agreed to provide medical services to members of the State Plan's indemnity medical plans according to the fees and other terms of the contract in exchange for a higher percentage of plan payment.

PRESCRIPTION BENEFIT MANAGEMENT COMPANY

A company on contract with the EBB to administer the Prescription Drug Plan for State Plan members. The company includes a network of retail pharmacy participating providers, mail-order services, on-line verification of eligibility, and on-line claims processing at the time services are received from a retail pharmacy participating provider.

PRESCRIPTION DRUG PLAN

The plan of prescription drug benefits described in Section K of this Summary Plan Document.

PREMIUM PAYMENT PLAN

A plan for paying your share of insurance premiums with pre-tax dollars rather than with after-tax dollars so you realize tax savings. This plan is offered in accordance with U.S. Internal Revenue Code (IRC) Section 125 and applicable federal regulations. See B.5 and Chapter 6 for information on this plan.

PREVIOUS COVERAGE CREDIT

Application of creditable medical coverage to the State Plan's one-year waiting period for coverage of a pre-existing medical condition, and application of creditable dental coverage to the State Plan's waiting period for coverage of a pre-existing dental condition. The waiting period is reduced by the amount of creditable coverage applied.

PRE-EXISTING CONDITION

A condition for which medical advice, diagnosis, care, or treatment (including prescription drugs) was recommended or received by a member within the six-month period ending on the member's enrollment date. Pregnancy and any conditions of an eligible dependent newborn or an adopted eligible dependent child are not pre-existing conditions.

PRIOR AUTHORIZATION

A process to inform you whether a proposed service, medication, supply, or ongoing treatment meets the following criteria for coverage by your selected medical, prescription drug, or dental plans:

1. Is medically necessary.
2. Complies with applicable medical policy.
3. Is a benefit of the plan.
4. In the case of a managed care plan prior authorization, whether it meets criteria for the in-network level of benefits.

See G.5 of this Summary Plan Document for more information on obtaining a prior authorization for dental plan and indemnity medical plan services. If you are on a managed care medical plan, see the Managed Care Plan Supplement to this document for that plan. See H.1 of this document for information on prior authorization of prescription drugs.

PROFESSIONAL HOME CARE (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Long-term care by a licensed home health organization or agency that may be eligible for benefits under long-term care insurance sponsored by the State Plan, depending on the care options plan you (or a family member) enrolled in, and other terms of the long-term care insurance policy (see Section R).

PROFESSIONAL PROVIDER

An individual who has satisfied the necessary qualifications to practice medicine within the State of Montana or another state or country. Professional providers may include, but are not limited to, physicians; mid-level

practitioners; naturopaths; podiatrists; or physical, occupational, or speech therapists.

PROTECTED HEALTH INFORMATION

Individually identifiable health information transmitted, including electronic transmission, or maintained in any form or medium.

QUALIFYING EVENT

An event that triggers a special enrollment period or allows a subscriber to make a mid-year change in benefits that affects the amount of premium paid pre-tax (see B.2, B.3, and B.5).

RATE SHEET

A document presenting employee and family premiums for each medical plan option, the Dental Plan, and available life and AD&D insurance plans, as well as the state contribution that can be applied to the premium costs. A new rate sheet is issued for each benefit year.

RECOVERY CARE BED

A bed occupied in an outpatient surgical center for less than 24 hours by a patient recovering from surgery or other treatment.

REHABILITATION THERAPY

Specialized treatment, for an injury or physical deficit, which meets the following criteria:

1. Provided in an inpatient or outpatient setting.
2. An intense, comprehensive program of therapies and services provided by a multi-disciplinarian team of health service providers who are licensed, certified, or otherwise approved to practice their respective professions in the state where the services are provided. This also includes associated general and medical services incidental to rehabilitation care.
3. Designed to restore the patient's maximum function and independence.
4. Under the direction of a qualified physician and includes a formal written treatment plan with specific goals.

Rehabilitation therapy includes physical therapy, occupational therapy, and speech therapy.

RESIDENTIAL PSYCHIATRIC CARE

Twenty-four-hour per day, voluntary, short-term, supervised psychiatric care provided by a facility licensed to provide residential psychiatric care.

RETIREE

A former state employee who meets the eligibility requirements of E.6.

SEVERE MENTAL ILLNESS

Severe mental illness shall mean conditions defined as severe under 33-22-706 MCA:

1. Schizophrenia.
2. Schizo-affective disorder.
3. Bipolar disorder.
4. Major depression.
5. Panic disorder.
6. Obsessive-compulsive disorder.
7. Autism.

SKILLED NURSING FACILITY CARE

Medically necessary inpatient skilled nursing services provided by an institution, or distinct part thereof, which is licensed pursuant to state or local law to provide skilled nursing services only. A skilled nursing facility is primarily engaged in providing continuous nursing care by, or under the direction and supervision of, a registered nurse for sick or injured persons during the convalescent stage of their illness or injuries. Skilled nursing facility care is not, other than incidentally, a rest home or home for custodial care or for the aged. In no event does this term include care by an institution or any part of an institution which is primarily engaged in the care and treatment of mental illness or chemical dependency.

SPECIAL ENROLLMENT PERIOD

A 63-day period triggered by a qualifying event in which an eligible dependent can enroll in the State Employee Benefit Plan (see B.2).

SPEECH THERAPY

Treatment for the correction of speech impairment resulting from disease or trauma.

STATE CONTRIBUTION

The monthly amount the State of Montana contributes toward the costs of State Plan insurance benefits for employees.

STATE EMPLOYEE BENEFIT PLAN (OR STATE PLAN)

The benefit plan described in this Summary Plan Document.

SUBSCRIBER

An individual who, by virtue of being a state employee, retiree, surviving dependent, or COBRA member, who:

1. has met the State Plan's requirements to enroll in the State Plan or independently continue State Plan coverage under the provisions of Section E;
2. is enrolled in the State Plan and any insurance plan offered by the State Plan to which the term is applied; and
3. is named as the subscriber by the EBB and by the insurance company as shown on its identification card.

SUMMARY PLAN DOCUMENT (OR DOCUMENT)

This document and supplements and amendments here to.

TOTAL HOME CARE (APPLIES TO LONG-TERM CARE INSURANCE ONLY)

Long-term care by anyone, including a family member or friend that may be eligible for benefits under the State Plan's Long-Term Care Insurance Plan, depending on the care options plan you (or a family member) enrolled in and other terms of the long-term care insurance policy (see Section R).

TRANSPLANT NETWORK

A network of transplant centers whose services are covered by the State Plan's indemnity medical plans as described in L.26 (currently the Blue Quality Centers for Transplant available to Blue Plans). For managed care plans, a network of transplant centers whose services are covered by the managed care plan according to the terms of the Managed Care Plan Supplement to this document. Institutions that participate in a transplant network must meet established criteria for quality and agree to a negotiated, all-inclusive rate for a package of transplant services that includes professional, facility and ancillary services, and/or a predetermined length of time.

VISION INSURANCE AND VISION INSURANCE COMPANY

Insurance that provides a schedule of vision exam and hardware benefits for adults and children enrolled in the plan. Vision insurance company refers to the company on contract with the EBB to provide vision benefits to State Plan members who are enrolled in the State Plan's vision insurance benefit plan. A copy of the controlling policy or certificate of coverage is available upon request.

PRODUCED BY THE
MONTANA DEPARTMENT OF ADMINISTRATION
EMPLOYEE BENEFITS BUREAU

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